THE INTERNATIONAL JOURNAL OF PSYCHO-ANALYSIS

Vol. XLI 1960 Part 6

CONSIDERATIONS REGARDING THE PARENT-INFANT RELATIONSHIP[1]

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Introduction

The subject 'The Theory of Parent-Infant Relationship,' assigned for the papers shared by Dr Winnicott and me for discussion at the International Congress in 1961, is a broadly inclusive one. It is my understanding that the Committee designing the programme intended that these papers should not merely give a résumé of generally accepted theory of parent-child relationship in very early childhood, but should deal especially with those aspects of the subject to which the authors have devoted special investigative attention and concerning which they have developed points of view expanding, elaborating, or even diverging from theories already widely accepted. I have therefore entitled this paper 'Considerations Regarding the Infant-Parent Relationship'. This assignment is a pleasing one since it presents the opportunity and the obligation to consolidate and clarify work on certain problems of infantile development which have preoccupied me throughout all of the years of my psycho-analytic practice.

It is necessary, too, to define our subject further. The term *infant* may be variously used. From the angle of the law, an infant is a person below the age of full maturity—generally fixed in our Western countries at 21.[3] The implication here is that the span of physical growth is definitely fulfilled by this time and that the mental capacity for full individual responsibility has correspondingly developed. In pediatric and general medical practice, the term *infant* is often used for the child who cannot yet walk. After this he becomes a toddler. Here then it designates approximately the first year or 18 months after birth. In certain educational groups, the infant is the child who may attend infant schools or not yet be in school at all. The distinction then corresponds in time to the oedipal period, the resolution of which gives an additional push of independence and expands the child's activity so markedly beyond the home and family circle. When in psycho-analysis we speak of the infantile neurosis, we generally also include the time through the oedipal period. Our Programme Committee, however, designated the period to be discussed now as comprising the first two years after birth. This corresponds to the stage of fairly adequate establishment of the skills of walking and talking and of the initial capacity for secondary process thinking. It is of especial interest as it includes the inception and early stages of ego development.

What seems conspicuous and significant here is that in whatever way the term *infancy* is defined, its limit appears to be marked by maturational attainments involving some defi-

[1] This paper, together with Dr Winnicott's paper in this issue, will be the subject of a discussion at the 22nd International Congress of Psycho-Analysis, Edinburgh, July-August, 1961.

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[3] This definition of maturity and infancy actually closely coincides with linear skeletal growth measurement, in the male. The fixing of the end of infancy at 18 in the female is also in accord with these biological growth statistics.

nite independence from the mother or from both parents. It is indeed with physical maturational factors[4] reaching meaningful stages in body structure, form, and function that this paper will concern itself; to examine the interplay of these with the parent-infant relationship and the accompanying effect on the psychic development of the infant. In his book *Ego Psychology and the Problem of Adaptation* (21) Hartmann points clearly and repeatedly to the influence of biological maturational processes and stages on ego development: and in conjunction with ego function, on the reality adaptation of the total personality throughout life.

It is a temptation to quote liberally here, since the book contains a discussion, rich in its suggestions, concerning the intrinsic interrelation between biological factors and psychoanalytic findings and theories. While Hartmann considers that the examination of biological growth processes does not, strictly speaking, belong within the field of psycho-analysis, he emphasizes that nonetheless some thought must be given to them in understanding fully the significance of psycho-analysis for education, sociology, and mental hygiene, difficult as these fields are to delimit and define. As he mentions (p. 4), already in 1936 Anna Freud in *The Ego and the Mechanisms of Defence* (4) (pp. 4–5) had defined the task of psycho-analysis as the attainment of ' the fullest possible knowledge of all the institutions (id, ego, and superego), of which we believe the psychic personality to be constituted and to learn what are their relations to one another *and to the outside world* ' (italics mine). Utilizing this, Hartmann adds, first, that it is possible however that psycho-analysis may be expected to furnish or become a general developmental psychology; and second, if and when this occurs, it must involve the study and appreciation of areas outside of the neuroses with which we habitually concern ourselves. He believes that an anticipation of this kind was entertained by Freud in the early years of his work when he referred repeatedly to the biological and physiological substructure of psychological phenomena, and it may again have been in his mind at the time of his writing ' Analysis Terminable and Interminable ' (1937) (7). ' After all,' Hartmann says, ' mental development is not simply the outcome of the struggle with instinctual drives, with love objects, with the superego and so on. . . . We have reason to assume that this development is served by apparatuses which function from the beginning of life. . . . Memory, associations, and so on, are functions which cannot possibly be derived from the ego's relationship to instinctual drives or love objects, but are rather prerequisites of our conception of these and their development ' (p. 15).

It is possible that the tendency rigidly to restrict the field of psycho-analysis to metapsychology in consideration of the established mental institutions was strengthened not only by the fact that psycho-analysis developed largely as a therapeutic method dealing essentially with pathological conditions, and the theory was influenced greatly by clinical investigations; but further, since the need to keep psycho-analytic treatment clear of other adjunct therapies is an essential one the vision of theory may have followed suit. Latterly the need to reaffirm strict boundaries of the preserve of psycho-analysis has resulted from its very popularity with the attendant danger of its dilution or degradation by those workers in our own and adjacent fields who enthusiastically embrace it without sufficient training in psychoanalysis itself and therefore sometimes work without adequate discrimination.

At any rate, if psycho-analysis is to develop a general psychological theory, as seems probable from an expansion of interest in the science of psycho-analysis itself, as well as from its inherent growth in its practical applications, then concern with related problems of biological development inevitably has a place. Stated even more specifically, the objection can no longer be raised that ' all of these problems are outside the field of psychoanalysis . . . . if we seriously intend to develop the ego psychology begun by Freud, and if we want to investigate those functions of the ego which cannot be derived from the instinctual drives. These functions belong to the realm (of). . . . the

[4] The terms *growth*, *development*, and *maturation* have been variously used by investigators. In general, *growth* has the connotation of increase in volume or weight; *development* may include this but emphasizes rather increase in elaboration of structure and/or functioning; whereas *maturation* stresses development in the direction of an optimal functional state. Since these terms have been used with such a degree of overlap in their meanings, to attempt to use them with a precise discrimination might be more confusing than clarifying. I am therefore following the decision of H. V. Meredith who reviewed the literature in 1945 (32), and using them interchangeably.

autonomous ego development. It is obvious that these apparatuses, somatic and mental, influence the development and the functions of the ego which uses them: . . . that these apparatuses constitute one of the *roots* (italics mine) of the ego ' (Hartmann, p. 101).

The Scope of this Paper

It is the purpose of this paper to indicate my conceptions concerning the mutual impact in the infant of maturational forces and the parental influences, predominantly those of the mother, during the first two years after birth. The special focus is on the development of the ego. I have long been impressed from a phenomenological angle with the appearance of certain stages, one might say nodes, of striving and of capacity for independent activity in the young child. Further these seemed to be in a close time relationship to definite stages of physical maturation: periods at which physical attainments, only recently impossible or uncertain, ' clicked '. The young infant then appeared to have a *feeling of gratification* in the achievement with subsequent increase in ease (a kind of physical confidence) apparent in the readiness and firmness of the do-it-again attitude of expectancy.[5] When one uses the term *striving*, as I have, it might seem to imply already the self-direction of a developed ego. What I am talking of is certainly on the borderland of ego development, but seems to me to be an expression of a maturation pressure to act or to move in a certain fashion, according to the unfolding of innate growth patterns, and to form the body groundwork of autonomous ego expansions.

It is easy to be misled in interpretations of such observations by the subjective elements in the observer. Medawar remarks, ' Everybody recognizes that there are indeed profound similarities between the behaviour of man and animals, but biologists and laymen think about them in entirely different ways. When laymen see mice nursing and cherishing their young, their first thought is, " How like human beings they are, after all!" The biologist (at all events when he is on duty) thinks, " How mouse-like after all are men!" ' (31). I have always felt cautious about extrapolating from observations of animal behaviour and making interpretations on the basis of its similarity to human behaviour. My use of a *biological* point of view has rather to do with efforts to understand developmental stages and problems in the human being from the angle of general biological principles, especially those having to do with growth and maturation.

I myself have never been a systematic direct observer of young children; many direct observations have been casual and involved with a personal relationship as well. I have however attempted to use the work of others (psychologists and pediatricians) especially concerning physical and behavioural maturation stages in infancy. This has been supplemented by the work of psycho-analyst colleagues, especially of those with wide clinical and theoretical interests. Primarily my own interest was stimulated early by Freud's ' Three Essays on Sexuality ' (8) in which he clearly saw the libidinal phase development as based on physical growth stages, and later repeatedly emphasized the constitutional elements in the source and intensity of instinctual drives.

Characteristics of Growth

Biological growth has certain general characteristics important for our understanding of the interrelation of mental and physical progress in the infant: *first*, it has a high degree of autonomy in its patterning: *second*, with some exceptions and variations it tends to progress in a cephalocaudal direction; *third*, the younger the organism, the greater the rate of growth (size, weight, and progressive differentiation); *fourth*, it proceeds with a reciprocal interweaving of development of related counteracting functions of neuromotor systems (e.g. extensor and flexor muscular capabilities), evident in periodic shifting of dominance of the component functions or systems with a progressive modulation and integration of resultant activity; *fifth*, it is subject to progressive fluctuations culminating in more stable conditions and responses; this has already been referred to as the tendency to reach stages or nodes before new directions of growth; *sixth*, in general it progresses according to an overall principle of individuation—i.e. development always involves a response of the organism as a whole and growth of any of its component parts or systems does not readily get markedly out of bounds. This response of the total organism, however, does not preclude a real uniqueness of the individual in specific details on a constitutional basis (12).

[5] This reminds one strongly of Hartmann's statement that the pleasure of the developing ego functions is an essential in the acceptance of reality (22).

The homeostatic organization of the individual is not as stable or efficient in infancy, however, as it is in later life. This principle of life seems to gain superior strength after the big increments and fluctuations of growth are past. In infancy the neonatal period (two to four weeks after birth) has an extremely high mortality rate, due probably to the inability of the newborn to adapt readily to the experience of birth, and especially to the changed environment. After the first two years of infantile life, the ego certainly plays an important role in synthesizing and integrating the various aspects of any given experience, whatever its nature (Nunberg) (34) (35). But this integrative tendency in the organism, which is related, possibly in an organic way, to the later homeostatic principle, exists in some degree even in the time before and during the early development of the ego, when experience does not involve any appreciable degree of true object relationship.

Perhaps at no stage is the autonomous character of the maturation processes so clear as in intrauterine life, where it is coupled, however, with an essential dependence of the embryo or foetus on the mother for life itself. Indeed without this complete maternal protective envelope and passively supplied nutrition the very young embryo could not increase in size and complexity because of the inevitable exorbitant need for sustenance simply to maintain its body heat, owing to the relatively high ratio of body surface to volume (31).

Ideas of the influence of the mother on the unborn have varied greatly from the old superstitious beliefs in prenatal marking by the attitudes and specific experiences of the mother to a concept of intrauterine life, also derived from fantasy, as completely exempt from any disturbing maternal influence. Our knowledge is still incomplete. But it seems significant that in general severe disturbance in the mother may, according to its nature, affect the nutrition and size of the foetus, or conceivably promote a heightened reactivity to certain stimulations. But it does not ordinarily interfere otherwise with the fetal growth patterns. It is evident however that there are epochs of intrauterine growth with acceleration of growth in size as well as in structural changes which are relatively greater than those occurring after birth. And there are special periods of vulnerability when external influences may have a catastrophic effect[6] (33). But in general the progress of development in size and form is steadfastly determined by endogenous rather than exogenous stimulations. Gilbert describes the anomalies of development as misfortunes of growth at critical stages (14). It is interesting too in connexion with the autonomous patterning of growth that the growth tendency in weight of premature babies after birth conforms to that of foetuses of the same size and age rather than to that of full term babies of the same chronological age, computed from the date of birth (Scammon 1922) (37).

The tendency of maturation to extend in a cephalocaudal direction is of importance in the concept of early determinants in ego development. It means that the maturation of the special senses, olfaction, vision, and hearing as well as the neuromuscular patterning of mouth activity is proportionately farther along at an early age than is that having to do with the movements of the hands and feet, or even of the trunk. Thus most observers find that focussing of the eyes occurs before, and is instrumental in furthering, controlled movements of the hand and lower arm. Earlier the arms and the legs tend to react as wholes, the impulses to action arising mainly from the shoulder and the pelvic girdles. As maturity advances, mobility asserts itself at the elbow and the wrist joints and at the knee and the ankle joints. From about four months on, the elbows and digits participate in reaching movements with increasing effectiveness until at nine or ten months they approximate to the shoulder effectiveness (Halverson) (20). But at four months, the eye muscles have already attained a fair degree of focussing. There is thus a definite time lag in the developing of controlled movement in forearm and hands behind that of visual movement and focussing. Even more striking is the disparity in time development of the control of movement at the two ends of the gastrointestinal tract. The movements of the mouth are well developed at birth, whereas control of the lower bowel is not attained for many months. This is so much an analytic truism that its implications as part of the sequential growth pattern may be readily overlooked. The question of the significance of the cephalocaudal maturational direction tendency will be discussed again in connexion with the development of the body ego.

[6] The first three months of pregnancy, when organogenesis is proceeding rapidly, is a period of special susceptibility to influence from maternal illness, notably rubella. The second three months (4–5–6 mos.) is much safer, and the third trimester again somewhat hazardous. Nelson's *Textbook of Pediatrics*, p. 27.

The Body Ego

Hoffer's papers (27) (28) (29) on the development of the body ego (1949-1950) offer an excellent starting-point for this discussion. On the general foundation of the conception put forward by Hartmann, Kris, and Loewenstein (23) that both ego and id arise from an undifferentiated state, rather than Freud's earlier formulation of the ego becoming differentiated from the id (1927) (9), and that the first and most fundamental step leading to ego differentiation ' concerns the ability of the infant to distinguish between the self and the world around him ', Hoffer proceeds to examine the possible ways in which the separation of the body self from ' the other ' (anything in the outer world) may occur.

Freud had spoken of internal perceptions, more fundamental and more elementary than the external ones to which the infant also responds, that is, the response of the body to itself and to the internal organs, with changing states of tension and relaxation. It would seem then that these might form a kind of central core of dim body awareness. If it is correct that the body states giving rise to these perceptions are by no means completely chaotic but are already knit together in some ways by the internal patterning of ontogenetic development, this quasi-organization in itself would contribute to the ' coreness ' of the primitive body image at its inception; and the problem of separateness would become largely focussed on the surface of the body,[7] and on the awareness of especially those functions involved in perceptions of contact of varying intensities.[8]

Touch is obviously important in the determination of the self from the non-self—of the body from the environment. Through it are mediated any perceptions of differences in temperature, texture, moistness, and many other subtle changes in kinaesthetic vibratory sensations and pressures, differences which gradually build up to some sense of degrees of separateness or of aloneness. Hoffer states that the special importance of touch in the development of the body ego lies in the fact that touching one's own body elicits two sensations of the same quality, and that as these areas with similar sensory responses become gradually united or confluent, an important step in the delimitation of the body from the outer world is achieved. But I would add that touch may also be a potent conveyor of the opposite—i.e. make for a sense of oneness with the other, or not-self, if the ' other ' is or approximates to the warm body of the mother or nurse. There is then a relatively small degree of difference in temperature, texture, smell, resilience, etc. (compared for instance with such qualities of inanimate objects), and the difference is one to which the infant has already become acclimatized.

The transitional object itself described by Winnicott (41) is a monument to the need for this contact with the mother's body, which is so touchingly expressed in the infant's insistent preference for an object which is lasting, soft, pliable, warm to the touch, but especially in the demand that it remain saturated with body odours. While the comfortable and familiar smelliness of the chosen transitional object is actually derived from the infant's own body, the fact that the object is usually pressed against the face close to the nose probably indicates how well it substitutes for the mother's breast or soft neck. It is virtually impossible for the infant to use any part of his own body for as good a simulation of the breast. His attempts with fingers and toes may be incompletely satisfying because of the lack of softness of the digits and their difference in configuration from the mounds and hollows of the maternal body.

It seems to me that vision is not only an adjunct but an indispensable one in establishing the confluence of the body surface and promoting awareness of delimitation of the self from the non-self. ' Touching ' and taking in of the various body parts with the eyes (vision) helps in drawing the body together, into a central image

[7] I have had the idea that the process of birth itself is the first great agent in preparing for awareness of separation; that this occurs through the considerable pressure impact on and stimulation of the infant's body surface during birth and especially by the marked changes in pressure and thermal conditions surrounding the infant in his transfer from intramural to extramural life (16).

[8] It is interesting in this connexion that the subcutaneous tissue tends to increase rapidly in thickness during the first nine months after birth, while growth of the body as a whole is decelerating. Thereafter it tends to diminish, so that by five years it is approximately half as thick as at nine months (Nelson's *Textbook of Pediatrics*, p. 15) (33). It is possible that this is part of a response to the need for heat conservation during a period in which growth, although decelerating, is still disproportionately great for the conditions of the external environment. A similar increase in subcutaneous tissue occurs in prepubescence and decreases again when the general growth impulse diminishes. In connexion with the fitting together of these various media of growth impulses it is interesting that this first post-birth increase in subcutaneous tissue diminishes at a time when peripheral locomotor activity (crawling, attempts at walking, and muscular play) has definitely entered a new phase.

beyond the level of mere immediate sensory awareness. Further the very functioning of visual perception in a focussed way (which is possible at an early stage in accordance with the cephalocaudal principle of maturation), as different from the reciprocal contacts between body parts by cutaneous touch, may offer a kind of nuclear beginning to an ego development at a mental level.[9] It is a self-observing function which gains significance as it combines with and oversees the self-perception of touch to form some kind of image of much of the body self, and to separate it from other objects, both animate and inanimate.

In Hoffer's papers he further traces the integration of the hand-mouth activity which emerges with increasing capacity for direction and control during the third and fourth months (10–16 weeks). He considers that (i) appearance of pleasure, (ii) the probable functioning of memory evident in the consistent use of definite patterns of finger and hand sucking, (iii) the possible existence of reality testing in the discarding of other objects offered, and (iv) the considerable control by the infant of his own need satisfaction through finger sucking—all of these developments indicate a definite ego beginning. I would agree fundamentally with all this, except that I would give a much more significantly important place to vision in the establishment of this organized control.

Certainly the pervasive and powerful influence of vision is soon apparent when the infant begins to indicate choice through his head movements (Spitz) (39). The *no* makes a refusal through a direct turning of the head to the side to dispose of the undesired stimulating object by removing it from vision; whereas the *yes* through up and down movement permits it to remain in the range of focus and be affirmed again and again. Thus the *no* seems related to an unsuccessful form of the negative hallucination which through its externalization gains the secondary force of communication. But the contrast between the affirmative and the negative is determined in large measure by the bilaterality of the eyes.

Maturation, Pleasure in Functioning, and the Beginning of Aggression

For a long time it has seemed to me that we must look for the primordial origins of aggression as well as of libidinal pleasure in the early processes of maturation. It may even be that aggression and bodily satisfaction are at times overlapping aspects of growth itself, i.e., satisfaction in the period before earliest inception of the ego or the establishment of any appreciable degree of object relationship. This is the period, especially of intrauterine life and the first weeks after birth, when the physical activity of the organism consists very largely of the multiplication of the cellular elements and their differentiation and organization into different organ systems. Even the active functioning of the different organs is generally much below that which will develop in later infancy and childhood. While the physical apparatuses are being perfected, the rate of growth in volume, weight, and complexity or organization is stupendous. If this were to continue unabated after the first three months of pregnancy, when organogenesis has been completed, all other life would soon be crowded out. But such growth paradoxically can occur only when the organism is in a relatively helpless state, and is primarily a growing rather than a going concern. After the third month of foetal life, independently active functioning begins to become apparent. The mother feels movements of the fetal extremities as kicks and pushes.[10] Growth, in the sense of increment, is diminished, although still prodigious compared to what it will be by the postnatal time when these kicking movements have begun to be used for crawling or early attempts at walking, or later when kicking is utilized as a hostility directed against the object.

The question of any *rudimentary pleasure in functioning* must here be raised, as well as its corollary, the way in which this leads over to or is connected with later *ego pleasure* in functioning. I have already referred to Hartmann's statement that the pleasure of developing ego functions is an essential in the acceptance of reality; and to Hoffer's conception that the appearance of

[9] Gesell remarks: ' The eyes take the lead in the conquest of and manipulations of space. The baby takes hold of the physical world ocularly long before he can grasp it manually. He can pick up a pellet 7 mm. in diameter fully 20 weeks before he picks it up with his fingers.' ' Ontogenesis of Infant Behavior ' (12).

[10] The foetal heart has begun to beat in the first month. Corner puts these facts very picturesquely: ' . . . the months before birth are in their way the most eventful part of life and we spend them at a rapid pace. At the beginning the body consists of one cell; by the time of birth, it has two hundred billion cells. . . . You had the beginnings of a brain before you had hands, and of arms before legs; you developed muscles and nerves and began your struggle ' (3, Chap. 1, ' The Embryo as Germ and as Archive ').

pleasure in the functioning of the hand-mouth movements is one of the criteria of beginning ego formation (at a mental level). I have mentioned the appearance of infantile gratification in achievement, for example in the beginning of walking. These references are all to behaviour at the very beginning or in the early stages of psychological ego development.

In prenatal and neonatal periods, however, there can only be a very primitive and basic form of narcissism. In Freud's early paper on narcissism (10) he refers to the 'narcissistic libido of the foetus', and again to the 'libidinal complement to the egoism of the instinct of self-preservation, a measure of which may justifiably be attributed to every living creature'. In the chapter on the Analysis of Anxiety, in *The Problem of Anxiety* (11) he expresses the belief that the foetus at birth cannot be aware of anything beyond a gross disturbance in the economy of its narcissistic libido resulting from the 'pressure of large amounts of excitation giving rise to novel sensations of unpleasure: numerous organs enforce increased cathexis in their behalf, as it were a prelude to the object cathexis soon to be initiated. . . .' (pp. 96, 97, 102).[11]

With these considerations in mind one may ask whether this early form of narcissism may not be described as the libidinal investment of growth, before independent life is at all possible. The further question arises whether the conception of unpleasure may not have its counterpart in an early form of pleasure: a prelude, perhaps little more than a relative resting stage of ease with diminished tension, a slight plateau in development such is as conceivably indicated at about the 3rd to 4th month of pregnancy, before the initiation of a new phase or a new form of activity occurs. It is important, however, that the diminished tension is not due to an arrest in activity but rather to a smoothness in performance of recently acquired activity. In infancy one sees such periods, I believe, around the 4th or 5th months and again around the 15th to 16th month, in relation to specific functional achievements. At these more general stages or nodes of development, there is a suggestion of well-being and of the fitting together and 'clicking' of interrelated activities with a temporary relief from the urgency of old pressures. New maturational drives may be felt then as pleasant stimulation rather than experienced yet as uncomfortable accumulations of tension. At such times, it would seem as though in the endless interweaving processes of growth, a fundamental part of the pattern has emerged more clearly.

What then are the antecedent stages in the development of aggression? But first, how shall we define or describe it? It is for the most part agreed that there are two sets of instinctual drives—the sexual and the aggressive drives. From a biological angle, these may be considered to be largely in the service of the continuation of the species and of the individual respectively. But from the angle of the individual life adaptation, obviously they cannot be reduced only to these terms. On the other hand, I find it helpful not to disregard completely the implications of the biological beginnings of activity even when trying to understand it at a psychological level. It may be for this reason that it is more difficult for me to grasp clearly the article on the theory of aggression by Hartmann, Kris, and Loewenstein (1949) (24), than Hartmann's discussion of ego psychology and the problem of adaptation (21) or his article on the psycho-analytic theory of the ego (22). In the first of these, any real consideration of the biological has been pretty much tidied out of the discussion in the interest of avoiding possibly murky speculation.

Hartmann, Kris, and Loewenstein speak of 'impulses of an aggressive nature, manifestations of destructiveness or *cruelty*' (italics mine). One is aware that with the addition of the term cruelty an animate object is implied, for cruelty involves suffering of another. Aggression at this level then can occur only with an established ego and the development of appreciable object relationship. I would prefer to consider aggressive instinctual drives first simply as destructive drives, or before the dawn of the ego and object relationship, to consider them as biological assertiveness, a manifestation of processes of growth.

If aggression is an instinctual drive, it must be potentially present in some degree of primitive organization before the development of the ego. It seems that the earliest form of aggression exists in the great expansion and evolution of

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[11] In early papers on 'The Biological Economy of Birth' and 'The Predisposition to Anxiety', Part I, I have made some attempts to discuss the theoretical implications of this concept of foetal narcissism (16) (17).

the newly fertilized ovum. In some unicellular organisms it is manifested in the pseudopodal activity by which the organism reaches out and envelops particles with which it comes in contact. In this simple form, aggression is a *going at* or *towards*, an *approaching* as the derivation of the word implies. In the fertilized ovum there is a marked increase in activity and an awesomely rapid increase in size, complexity, and organization after implantation in the uterine wall. Already a peculiar biological partnership has been set up between embryo and host, in which the partners are continuously more intimately together and more separate than in any other relationship in life.

But my point here is that since the embryo and its maternal host are now obligatorily a combined concern, in which the mother's body is the nutrition gatherer for the embryo and the supply is lavish, this energy of the primordial aggression is not needed for the attainment of nutrition and can be utilized in biological creativeness in the building up and the functional differentiation of the organs. Thus the mother's body has taken over almost completely the satisfaction of embryonic destructive drives. If we accept at all the biological conception of ontogeny repeating phylogeny we are confronted with the extraordinary situation of this energy going into a life, in a sense apart from the embryonic environment (the uterine cavity) which is, however, a reliving of the reactions to all the environments of aeons past. This is a feat which is almost beyond our true comprehension. It is not that the assertive drive is turned inward against the organism, as we might later conceive it to be, in an established organism, when it then becomes self-destructive, but it is still in a sense an outward drive in which the environments of the past are internalized as part of the process of developing organization, in an unbelievably condensed recapitulation. Once this cycle has been completed and the foetus has caught up with time, then such an enforced passivity might endanger rather than promote the development of the organism. Is this turning of the energy into the work of organizational growth a change in the nature of the energy?

When the period of the first three months of organogenic growth is past, and the nervous and muscular systems are sufficiently well developed, the energy begins to be peripherally directed again and movements of the extremities occur. The mother ' feels life ' in the fourth month. Even earlier movements can be elicited by specific stimulations in embryos removed from the body, but by the fourth month they seem to occur regularly owing to the reaching of some kind of integration point of the functional processes going on in connexion with the autonomously interweaving undertakings of maturation. During the later months of pregnancy there is an increasing amount of peripherally directed activity.

After birth the infant must begin to fend even more for himself, taking the nourishment aggressively from his mother through nursing, rather than receiving it passively through his blood stream. But it is at the times of the auspicious harmonizing of related functions, the arrival at a fairly smooth meshing of these functions to reach a more complex economizing activity, that the body ego develops and contributes to the beginning mental ego. I would refer here again to Hartmann's statement, ' These apparatuses, somatic and mental, influence the development and functions of the ego which uses them—that these apparatuses constitute one of the roots of the ego ' (21). This is in keeping too with Freud's early statement that pleasure tended to be linked with the self and unpleasure with the outside-the-self. It is also related to the concept of Hartmann, Kris, and Loewenstein, who say ' Every step in the formation of the object corresponds to a phase in psychic differentiation. That differentiation itself is determined by the *maturation* of the apparatus, which later comes under the control of the ego, and by the experiences which structure the psychic apparatus. Hence both processes, differentiation of psychic structure and relation of the self to external objects are interdependent ' (23, p. 27). Again, ' The formation of the ego can in part be described as a learning process, which supplements the growth of the apparatus of the ego. The gratification of demands stemming from instinctual drives is guaranteed by learning ' (23, p. 13). What I have been considering is the prelude to this, the biologically autonomous beginnings, which have been described as belonging to the no-man's-land between biology and psychology (Hoffer) (29). It is probably important that in prenatal life there is the beginning of a brain before there are hands.

But we are now confronted with the question of the fate both of the raw aggression of infancy and of the concomitant pleasure in functioning which seem so important in the formation of the

ego and later are utilized by it. This brings us to the next division of this paper.

The Parent-Infant Relationship and Maturation

'The children most physically endangered by the present state of affairs [i.e. conditions of disrupted family life under war conditions in London] are those up to two years of age. It is easy to understand that infants simply cannot live in a state of emergency. . . . Development demands its own conditions, irrespective of war and peace or all other happenings in the outer world' (Freud-Burlingham Reports) (6).

During the first two years after birth, one of the main tasks of the infant undoubtedly has to do with making a sound separation from the mother and the commencement of an individual existence, with the later establishment of the sense of reality, of early object relationship, the beginning of secondary process thinking, and the first stages of the sense of identity, in conjunction with, interdependent with and under the mediation of the young ego.

The infant begins by having to work for a living in nursing and continues by taking over gradually and with the mother's co-operation the other concerns of his body life. The pleasure in and control of the satisfaction of his bodily demands and functions—his pregenital sexual life, proceeds according to rather well marked phases, determined by maturational development associated with the different body zones involved. It is not necessary for the focus of this paper to recapitulate much concerning early libidinal phase development which was one of the cornerstones of Freud's early observations and the beginning of analytic theory. I shall pay more attention now to thoughts concerning the evolution of the early ego. There are certain comparisons, interrelations and contrasts between ego and libido developments.[12] But this will be referred to again somewhat later.

During the early part of this period it is obvious that the mother or her substitute is the exclusively important person in the infant's life. The father may play a role as a substitute for the mother but his more muscular body is a less acceptable cushion than is that of a nurse or other female helper. This is especially true during the undifferentiated phase, immediately succeeding the neonatal lethargy and extending into the greater part of the first year.

By the time of birth the sensitivity of the body surface is well developed in the mouth area especially, where skin and mucous membrane responses are active and the neuromuscular pattern for sucking is well established. But in addition to the hunger needs, the contact with the mother's body to supply warmth and exercise through its motion is essential, as the work of Spitz (38) and others (1) (2) (36) has specifically demonstrated. It is probable that the rhythm of the maternal movements associated with body warmth offers the infant a partial reinstatement of prenatal conditions and helps bridge over the transition from intramural to extramural life. With the infant a little more advanced or in an alert awake state rather than a sleepy one, the body contact with the mother may offer stimulation and a degree of toning up of peripheral muscles which helps in their functional maturing. Naturally then the ease and freedom from tensions with which the mother accepts these reciprocal activities contributes much to the well-being of the infant.

This fluctuation between oneness with the mother and separateness from her either through temporary loss of contact with her or through the experiencing of strong own body sensations different from what have been experienced in contact with her seems very important, as it furnishes the beginning of what will become a psychological separation as well.[13] While it is believed that the awareness of the boundary between maternal and own body experience is at

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[12] See papers of Hartmann, and Hartmann, Kris, and Loewenstein already mentioned, and Hartmann in 'Comments on the Psychoanalytic Theory of the Ego' (22).

[13] On the basis of clinical psycho-analytic observations, I have thought that infants who slept habitually in bed with their parents were stimulated by primal scene activity and took on through vision, hearing, and kinaesthetic sensory responses the excitement of the motility, incorporating it into general body excitability. Naturally in cases of this kind, frequently the repeated exposure to the primal scene goes on throughout a long span of time in infancy. It is not easy then to determine what is incorporated from the first months and how much it adds to the intensity of responses to exposures of a later period. Certainly young infants react markedly and in highly individual ways to both motion and sound.

On the other hand, early deprivation of stimulation from body contact and from being handled may have serious consequences. It is well known now that babies treated by routine mass methods, as in some foundling hospitals, suffer severely in physical health as well as in their emotional development. The deficiency in bottle feeding as a substitute for breast feeding may be largely in the loss of the exercise of being handled and of the stimulation of body contact. This is especially true where bottles are propped and only the mouth and cheeks are active in the feeding.

first non-existent or very dim and then uncertain, it is evident that there is a gradual increase in the appreciation of differences.

By the end of the first six months, there is the appearance of actively asserted pressure *against* the mother as part of the growing maturational separateness. Specifically during the fourth to sixth months, it is very common to see an infant jump up and down while being held by the mother while she remains seated. As the baby pushes in a somewhat bouncing motion with his feet against her thighs or abdomen, he shows unmistakable signs of pleasure with gurgling and laughing. His activity involves ability to extend the legs and the trunk as well in rhythmic co-ordinated movements, with a much more powerful thrust than he has been able previously to command. The appearance of signs of some degree of gratification is convincing. This behaviour occurs after the extraocular muscles have matured and movements of the eye are fairly well controlled. Ordinarily then the infant is in visual contact with the face of the mother as he thus dances against her body. Earlier too, he has been wont to touch her breast and then her face with his hand in a fumbling way, but generally without much force. It is my belief that this forceful pressing or pushing activity is part of a definite phase resulting from favourable maturational development and a meshing of related functional activities to permit this new step, with some inner feeling of exhilaration and bodily confidence. It is comparable to what Hoffer described between hand to mouth and finger selection for sucking in his paper on the ' Development of the Body Ego ' (27). But at this stage there is a correlation of activity of the legs, arms, and trunk, involving also vision—with the appearance of the very beginning of object relationship to the mother. The physical aggression in this behaviour is striking even though one cannot think in terms of motivation, but rather of a degree of biologically autonomous againstness, which combines with and may be augmented by the mother's tendency to respond with reciprocal motion. In this activity there may be an increasing sense of physical power and of the ability to initiate motor activity and to control it to a degree. There may also be a certain amount of reality testing in the rhythmic quality of back-and-forthness, reminding us of the throwing of the ball (which will occur later) and the pleasure of having it returned, or of the peek-a-boo game. Furthermore, the relationship to the object (the mother) is generally maintained through vision, throughout the play. A little later babies do not need the mother's cooperation and will go through these alternately bending and straightening up motions while hanging on to a crib side or a chair.

According to my observations, partly direct but casual ones in caring for children, and in part through reconstructions in working with adult patients, there are also later stages of body maturation and awareness linked with phases of ego development. One occurs at about the fifteenth to sixteenth month or so and seems to be associated with the accomplishment of walking. A later one is associated with the period of the phallic phase.[14] In both of these there is certainly a component pleasure of skin, muscle, and kinaesthetic erotism; further the genital contribution to the total body exhilaration is most apparent in the phallic phase. This, however, is beyond the limits set for this paper. But the pleasure has also an element of reaction to integration, organization, and mastery, which shows in an attitude of confidence and assurance in repetition.[15] It is experienced in connexion with executive activities which predominantly involve a reaction to and on the environment, rather than a primary focus on control of bodily functions, as is the case in the activities of the special erogenous zones in the libidinal phase development. Still there is much in common and a certain amount of interrelation between the patterning of the aggressive instinctual drives and that of the sexual ones.

In the development of control of both sets of instinctual drives the attitude of the infant's partner, the mother, is of paramount importance. We are familiar with the fact that attention to self-demand in feeding and to the use of trial situations in toilet training seems to be helpful in selecting of *timing* for the regulation of schedules both for feeding and toilet training. This is then in accordance with the maturational readiness of the infant to respond adequately and with a minimum of strain. Essentially this means the appreciation of the baby as a developing organism rather than as a miniature adult,

[14] I have mentioned these elsewhere chiefly in connexion with disturbance of their development in the perversions (18). Loewenstein also has noted the possible relation between these last two periods (that at about sixteen months and that at four years) with respect to ego development (30).

[15] Compare Hendrick's conception of an instinct of mastery (25) (26).

and may indicate a developed object relationship rather than a narcissistic one on the part of the parent towards the infant. It is also a matter of clinical experience that great distortion in the timing of the management of libidinal phase activities together with the accompanying disturbance in infant-mother relationship tends to promote a fixation on the special erogenous zone. Some increase in ambivalence and the provocation of conflictual aggression with consequent defence formation then occurs.

According to my conception somewhat comparable conditions may arise from an inadequate cooperation between mother and infant, if she fails to accept and respond to the maturation needs of the infant's aggressive drives, as these emerge into new constellations of organized activities. Disturbances seem to arise especially with respect to her failure to accept the infant's growing separation from her, or to see readily enough the spurts of aggressive behaviour as part of growing motor executive abilities rather than as simply increasing destructive urges threatening to the infant and to the property around him. In such instances, by curbing the child excessively either with actual physical restraint or with constantly anxious responses to his activity, she prevents the optimal utilization of the energy of the aggressive drives in the biologically creative formation of new body skills. This further interferes with the attendant pleasurable gratifications and promotion of body ego and early mental ego development. Instead there is then an increment in the destructive or cruel aggressive drives. Object relationship is impeded and turned in a hostile direction, in reaction to the interference with the maturation pressures. In attitudes of anxious restrictiveness the mother may then promote exactly what she has thought she wished to guard against, viz. outbursts of destructive temper and some constriction of learning.[16] Marked and consistent interference of this kind may result in impairment of sound ego development. Conversely an optimal empathic response to and support of the infant's developmental needs by the mother will result in utilization of a suitable portion of aggressive energy in constructive enterprise with attendant gratification. This situation strengthens ego development and promotes functions which are later the concern of the well developed ego.[17]

This seems to me a paradigm of that part of character structure in which the ego is able to ' neutralize ' an amount of aggressive energy and use it in constructive service, first in the organization of body motility and later in the attainment of more elaborated skills of use in social relationships. This is in contrast, on the one hand to the almost exclusive abandonment to the gratification of aggressive discharge with a minimal ability to check impulses and, on the other, to the control of aggression in compulsive reaction formation with the development of strong competitive drives, conditions which may follow poor maternal handling. In the latter case the choice of activity for development of skill may be socially acceptable. But the aim of the aggressive drive is still primarily a gratification of the sadism through ' beating out ' the other in competition. The apparent ego strength is then more a matter of durability, maintained at the expense of flexibility and of primary enjoyment in fruition of the skill itself. In the end, the sadism, with its attendant conflicts, may then invade or constrict other areas of character development.

The Sense of Identity, and Early Identifications in Infancy

So far, this discussion has been concerned largely with the development of the first year of life, the dependence on the mother and the increasing separation from her, owing to the maturation processes feeding infantile autonomy. The second year of life is psychologically infinitely more complex. In the first year the attachment to the mother has been established largely on the basis of her being a need-fulfilling person; ' in the second year, the child loves her

[16] In connexion with the infantile reaction to restraint, J. H. Taylor, an experimental observer, concluded that infant responses to restraint (after the first few weeks) depend not so much on the external stimulus as upon an *internal* condition. Consequently the evaluation of observations in terms of external stimulus and overt behaviour may give rise to erroneous conclusions (40).

F. Goodenough, studying temper outbursts in early childhood, found that shows of temper in the first year occurred mostly in connexion with routine care such as dressing and bathing. By two years, however, temper outbursts occurred largely in connexion with conflict with the mother over establishment of routine habits and about equally in conflict with her over authority in matters not directly connected with habit training. These were early studies, when pediatric advice generally was in the direction of early ' habit training ' rather than fitting this to the maturational needs of the infant (15).

[17] The acceptance of the aggressive pressures and assertiveness of the infant does not mean, however, a complete permissiveness and lack of any restrictions, as has sometimes been attempted by ' progressive ' parents. For a discussion of these aspects of the situation see A. Freud (4).

as a separate person' (Freud and Burlingham Reports, p. 49) (6). Already after the first months of the first year and well established in the second year, is the infant's reaction to the father, which seems rarely as intense as it is towards the mother, probably owing to the lesser constancy and bodily intimacy of the contact. By this time, however, the infant may well respond to the more vigorous play of some fathers, and differentiate quite clearly his expectations as to what may be obtained in this respect from each parent. The father's place is increasingly important and complex.

The accomplishment of walking, ordinarily around 15–16 months, seems to be the definite crossing of a threshold of development and contributes, through its combination of rhythm and space, to an early stage of organization of secondary process thinking, with a strengthening of the sense of time, and of sequence. With walking there is an enlargement of the capacity of re-visiting and re-experiencing exploratory activities, which in turn lends support to the developing sense of reality, and to the very beginning of associations which will lead in the direction of awareness of consequences and reasoning. Extravertive behaviour—throwing or casting toys out, pushing chairs and small objects around—is increased; sensory experiences are multiplied and may be increasingly experienced on the infant's own initiative. I have several times watched infants at this stage (when walking can be achieved with confidence) in their delighted exploration of a wide variety of sensory experiences in a garden: smelling the flowers, patting them, feeling the texture of stones, gravel, sand; listening to the sounds of a fountain with a kind of sophisticated attention. Walking has permitted an enormous increase in the infant's world under his own relative control.

Simultaneous with this awareness of the outer world is an increasing awareness of his own body and body functions. The infant begins to pay attention to his own urinary puddles, after they have occurred, but does not show by sound or gesture a differentiation between urination and bowel movement. During the next few months there is ordinarily an increasing strength of sphincter control and regularity of rhythm; and by a year and a half or so he may communicate his excretory needs before he sees the products (13) (pp. 33–34). Greater precision of observation of his own body and the bodies of others develops, and by the end of the second year there is an awareness of similarities and differences between the self and others, with respect to body parts and their representatives in clothing, and the expression of preferences and distastes. All this is part of the growing sense of identity and individuality, such that by the end of the next year (at 3) the young child regularly knows and can verbalize his name, his sex, and the basic facts of his family orientation (13).

There is some indication that in the first year after birth, and especially after the fourth or fifth month, the infant shows a fluctuating primitive identification alternating with a progressively increasing depth of separateness from the objects around him. This is based on his helplessness and his functioning actually as a part of and at the mercy of others and the capacity and constancy of the mother as a need-fulfilling agent. This primitive identification is thus quite different from identification, as we understand it, after the establishment of the ego, when it may be a passive, fated identification through awareness of likeness to another individual, or an active one in the wish to be or become so in form or functioning. Already sexual differences are noted, in accordance with the opportunities for observation; other differences, such as hair texture and colour, are commonly noticed.

By the sixth month after birth there is a quasi-automatic responsiveness in smiling, and the taking over through vision and body contact of the moods and tensions of others in the environment. This responsiveness gradually becomes a more complex imitativeness. By the end of the first year, an infant may go through motions imitating an adult lighting a cigarette or doing some other special task (Gesell) (13). It is doubtful whether this is an identification in the sense of a strong wish to be like another special person, such as might be clear a year later. It seems rather that it is a transitional stage between primitive identification and the more purposeful object identification which is just beginning. It may partake of the wish to try out whatever is seen in activity and be in part a motor exploration. But during the latter half of the second year, quite complicated imitations are attempted, expressing the wish to become or to recall the imitated person.

Certain characteristics of states of primitive identification have impressed me through clinical observations, though I am by no means sure that others would agree with them. While this identification belongs to the stage of incomplete

differentiation between the self and the other, and is superseded in importance by object-related identifications after the establishment of the ego and the sense of self, still it seems never to be completely abandoned. It can be and generally is repeatedly reactivated under special conditions of later life. It seems to me to be the basic nucleus of empathy and possibly one of the essential ingredients of the matrix from which transference reactions develop. Further it may throughout life be powerfully activated by contact with intense moods of others which then become highly communicable. This is especially true in group situations involving states of emotional excitement and may become an important factor in group irrationalities, such as riots and states of religious excitement.

It has also seemed to me that prolonged and unrelieved contact of an infant (during the first year or year and a half after birth) with another individual, usually another child, leaves a permanent effect of diminished differentiation of the self from the other, and consequently weakens and confuses the sense of identity, producing an effect somewhat simulating twinning (19). I have especially noticed this in certain perversions, where it seemed to contribute, along with other factors, to the uncertain sexual identity.

Concluding Remarks

In the time at my disposal for the preparation of this paper and in consideration of the reader's span of endurance, I found it not feasible to cover the subject of the *Theory of the Parent-Infant Relationship in the First Two Years* in its entirety. I have therefore limited myself to a discussion of selected problems of development within this broad framework. I have chosen those aspects of the parent-infant relationship which are especially constellated around and by the maturational forces in the infant. Here again, I have had to establish some further limits and have focussed almost exclusively on the biological beginnings of aggression as it is involved in skeletal muscle maturation, and the relation of this to the development of the ego.

I conceive of maturation as proceeding by certain stages according to general principles of growth. These stages are marked by periods of special activity accomplishment (organic learning) and are accompanied by the appearance of pleasure. The first postnatal stage of this kind seems to appear at about five months and marks the first clear separation from the mother which is under the infant's control; and is followed by the definite emergence of the beginning mental ego. Thus there is a contrast to the earlier development arising from purely biologically determined forces in the infant, supplemented by maternal contact and care. Throughout this period of early ego emergence, the mother (or her substitute) is the partner to the infant in responsiveness to his functional attainments. Her attitude is highly important in determining how much the innate aggressive instinctual drive may be augmented by frustration at these critical periods—or the opposite—the development of gratifying and ego-strengthening realization of accomplishment.

The development of the libidinal phases has been but scantily dealt with as it has been rather thoroughly described elsewhere. There is the serious omission, however, of the contribution of oral aggression as evident in crying, biting, and the development of speech. It is of some interest, for example, that biting of the mother's nipples associated with the eruption of teeth coincides in time with the five-month period of maturation in skeletal muscle activity, and that crying seems to change from an undifferentiated type of discharge to a more specific and somewhat controlled one in the same era. The emergence of patterns of essentially visceral muscle activity with an interplay with skeletal muscle in gesture as part of communication, forms an integral part of early aggression. Certain early forms of excretory aggression might merit consideration here, though the intensity of their influence belongs more to the period between 12 and 36 months.

The developments of the second year after birth (especially the period of 18 to 24 months) having to do with the establishment of secondary process thinking, memory, the sense of reality, identifications, and the sense of identity are only briefly sketched. The consummation of speech belongs to this period also. One is impressed with the flowering of the complexities and subtleties of the infant's development after the second period of maturational achievement which I have described as occurring at about 15 to 16 months, with the accomplishment of walking.

I trust that I may be pardoned the omissions and inadequate treatment of some parts of this broad subject, with the hope to remedy these in further studies in the future.

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THE THEORY OF THE PARENT-INFANT RELATIONSHIP[1]

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The main point of this paper can perhaps best be brought out through a comparison of the study of infancy with the study of the psycho-analytic transference.[2] It cannot be too strongly emphasized that my statement is about infancy, and not primarily about psycho-analysis. The reason why this must be understood reaches to the root of the matter. If this paper does not contribute constructively, then it can only add to the existing confusion about the relative importance of personal and environmental influences in the development of the individual.

In psycho-analysis as we know it there is no trauma that is outside the individual's omnipotence. Everything eventually comes under ego-control, and thus becomes related to secondary processes. The patient is not helped if the analyst says: 'Your mother was not good enough . . . your father really seduced you . . . your aunt dropped you.' Changes come in an analysis when the traumatic factors enter the psycho-analytic material in the patient's own way, and within the patient's omnipotence. The interpretations that are alterative are those that can be made in terms of projection. The same applies to the benign factors, factors that led to satisfaction. Everything is interpreted in terms of the individual's love and ambivalence. The analyst is prepared to wait a long time to be in a position to do exactly this kind of work.

In infancy, however, good and bad things happen to the infant that are quite outside the infant's range. In fact infancy is the period in which the capacity for gathering external factors into the area of the infant's omnipotence is in process of formation. The ego support of the maternal care enables the infant to live and develop in spite of his being not yet able to control, or to feel responsible for, what is good and bad in the environment.

The events of these earliest stages cannot be thought of as lost through what we know as the mechanisms of repression, and therefore analysts cannot expect to find them appearing as a result of work which lessens the forces of repression. It is possible that Freud was trying to allow for these phenomena when he used the term primary repression, but this is open to argument. What is fairly certain is that the matters under discussion here have had to be taken for granted in much of the psycho-analytic literature.[3]

Returning to psycho-analysis, I have said that the analyst is prepared to wait till the patient becomes able to present the environmental factors in terms that allow of their interpretation as projections. In the well-chosen case this result comes from the patient's capacity for confidence, which is rediscovered in the reliability of the analyst and the professional setting. Sometimes the analyst needs to wait a very long time; and in the case that is *badly* chosen for classical psycho-analysis it is likely that the reliability of the analyst is the most important factor (or more important than the interpretations) because the patient did not experience such reliability in the maternal care of infancy, and if the patient is to make use of such reliability he will need to find it for the first time in the analyst's behaviour. This would seem to be the basis for research into the problem of what a psycho-analyst can do in the treatment of schizophrenia and other psychoses.

In borderline cases the analyst does not always wait in vain; in the course of time the patient becomes able to make use of the psycho-analytic interpretations of the original traumata

[1] This paper, together with Dr Greenacre's paper in this issue, will be the subject of a Discussion at the 22nd International Psycho-Analytical Congress at Edinburgh, July/August 1961.

[2] I have discussed this from a more detailed clinical angle in 'Primitive Emotional Development' (10).

[3] I have reported (18) some aspects of this problem, as met with in the case of a female patient while she was in deep regression.

as projections. It may even happen that he is able to accept what is good in the environment as a projection of the simple and stable going-on-being elements that derive from his own inherited potential.

The paradox is that what is good and bad in the infant's environment is not in fact a projection, but in spite of this it is necessary, if the individual infant is to develop healthily, that everything shall seem to him to be a projection. Here we find omnipotence and the pleasure principle in operation, as they certainly are in earliest infancy; and to this observation we can add that the recognition of a true ' not-me ' is a matter of the intellect; it belongs to extreme sophistication and to the maturity of the individual.

In the writings of Freud most of the formulations concerning infancy derive from a study of adults in analysis. There are some childhood observations (' Cotton reel ' material (5)), and there is the analysis of Little Hans (3). At first sight it would seem that a great deal of psychoanalytic theory is about early childhood and infancy, but in one sense Freud can be said to have neglected infancy as a state. This is brought out by a footnote in ' Formulations on the Two Principles of Mental Functioning ' (4, p. 220) in which he shows that he knows he is taking for granted the very things that are under discussion in this paper. In the text he traces the development from the pleasure-principle to the reality-principle, following his usual course of reconstructing the infancy of his adult patients. The note runs as follows:

' It will rightly be objected that an organization which was a slave to the pleasure principle and neglected the reality of the external world could not maintain itself alive for the shortest time, so that it could not have come into existence at all. The employment of a fiction like this is, however, justified when one considers that the infant—provided one includes with it the care it receives from its mother—does almost realize a psychical system of this kind.'

Here Freud paid full tribute to the function of maternal care, and it must be assumed that he left this subject alone only because he was not ready to discuss its implications. The note continues:

' It probably hallucinates the fulfilment of its internal needs; it betrays its unpleasure, when there is an increase of stimulus and an absence of satisfaction, by the motor discharge of screaming and beating about with its arms and legs, and it then experiences the satisfaction it has hallucinated. Later, as an older child, it learns to employ these manifestations of discharge intentionally as methods of expressing its feelings. Since the later care of children is modelled on the care of infants, the dominance of the pleasure principle can really come to an end only when a child has achieved complete psychical detachment from its parents.'

The words: ' provided one includes with it the care it receives from its mother ' have great importance in the context of this study. The infant and the maternal care together form a unit.[4] Certainly if one is to study the theory of the parent-infant relationship one must come to a decision about these matters, which concern the real meaning of the word dependence. It is not enough that it is acknowledged that the environment is important. If there is to be a discussion of the theory of the parent-infant relationship, then we are divided into two if there are some who do not allow that at the earliest stages the infant and the maternal care belong to each other and cannot be disentangled. These two things, the infant and the maternal care, disentangle and dissociate themselves in health; and health, which means so many things, to some extent means a disentanglement of maternal care from something which we then call the infant or the beginnings of a growing child. This idea is covered by Freud's words at the end of the footnote: ' the dominance of the pleasure principle can really come to an end only when a child has achieved complete psychical detachment from its parents '. (The middle part of this footnote will be discussed in a later section, where it will be suggested that Freud's words here are inadequate and misleading in certain respects, if taken to refer to the earliest stage.)

The Word ' Infant '

In this paper the word infant will be taken to refer to the very young child. It is necessary to say this because in Freud's writings the word sometimes seems to include the child up to the age of the passing of the Oedipus complex. Actually the word infant implies ' not talking '

[4] I once said: ' There is no such thing as an infant ', meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant. (Discussion at a Scientific Meeting of the British Psycho-Analytical Society, *circa* 1940). Was I influenced, without knowing it, by this footnote of Freud's?

(*infans*), and it is not un-useful to think of infancy as the phase prior to word presentation and the use of word symbols. The corollary is that it refers to a phase in which the infant depends on maternal care that is based on maternal empathy rather than on understanding of what is or could be verbally expressed.

This is essentially a period of ego development, and integration is the main feature of such development. The id-forces clamour for attention. At first they are external to the infant. In health the id becomes gathered into the service of the ego, and the ego masters the id, so that id-satisfactions become ego-strengtheners. This, however, is an achievement of healthy development and in infancy there are many variants dependent on relative failure of this achievement. In the ill-health of infancy achievements of this kind are minimally reached, or may be won and lost. In infantile psychosis (or schizophrenia) the id remains relatively or totally 'external' to the ego, and id-satisfactions remain physical, and have the effect of threatening the ego structure, until, that is, defences of psychotic quality are organized.[5]

I am here supporting the view that the main reason why in infant development the infant usually becomes able to master, and the ego to include, the id, is the fact of the maternal care, the maternal ego implementing the infant ego and so making it powerful and stable. How this takes place will need to be examined, and also how the infant ego eventually becomes free of the mother's ego support, so that the infant achieves mental detachment from the mother, that is, differentiation into a separate personal self.

In order to examine the parent-infant relationship it is necessary first to attempt a brief statement of the theory of infant emotional development.

Historical

In psycho-analytic theory as it grew up the early hypothesis concerned the id and the ego mechanisms of defence. It was understood that the id arrived on the scene very early indeed, and Freud's discovery and description of pregenital sexuality, based on his observations of the regressive elements found in genital fantasy and play and in dreams, are main features of clinical psychology.

Ego mechanisms of defence were gradually formulated.[6] These mechanisms were assumed to be organized in relation to anxiety which derived either from instinct tension or from object loss. This part of psycho-analytic theory presupposes a separateness of the self and a structuring of the ego, perhaps a personal body scheme. At the level of the main part of this paper this state of affairs cannot yet be assumed. The discussion centres round the establishment of precisely this state of affairs, namely the structuring of the ego which makes anxiety from instinct tension or object loss possible. Anxiety at this early stage is not castration anxiety or separation anxiety; it relates to quite other things, and is, in fact, anxiety about annihilation (cf. the aphanisis of Jones).

In psycho-analytic theory ego mechanisms of defence largely belong to the idea of a child that has an independence, a truly personal defence organization. On this borderline the researches of Klein add to Freudian theory by clarifying the interplay of primitive anxieties and defence mechanisms. This work of Klein concerns earliest infancy, and draws attention to the importance of aggressive and destructive impulses that are more deeply rooted than those that are reactive to frustration and related to hate and anger; also in Klein's work there is a dissection of early defences against primitive anxieties, anxieties that belong to the first stages of the mental organization (splitting, projection, and introjection).

What is described in Melanie Klein's work clearly belongs to the life of the infant in its earliest phases, and to the period of dependence with which this paper is concerned. Melanie Klein made it clear that she recognized that the environment was important at this period, and in various ways at all stages.[7] I suggest, however, that her work and that of her co-workers leaves open for further consideration the development

[5] I have tried to show the application of this hypothesis to an understanding of psychosis in my paper: 'Psychoses and Child Care' (15).

[6] Researches into defence mechanisms which followed Anna Freud's 'The Ego and its Mechanisms of Defence' (1) have from a different route arrived at a re-evaluation of the role of mothering in infant care and early infant development. Anna Freud (2) has reassessed her views on the matter. Willi Hoffer also has made observations relating to this area of development (8). My emphasis in this paper, however, is on the importance of an understanding of the role of the early parental environment in infant development, and on the way this becomes of clinical significance for us in our handling of certain types of case with affective and character disorders.

[7] I have given a detailed account of my understanding of Melanie Klein's work in this area in two papers (16, 21). See Klein (9, p. 297).

of the theme of full dependence, that which appears in Freud's phrase: '. . . the infant, provided one includes with it the care it receives from its mother . . .' There is nothing in Klein's work that contradicts the idea of absolute dependence, but there seems to me to be no specific reference to a stage at which the infant exists only because of the maternal care, together with which it forms a unit.

What I am bringing forward for consideration here is the difference between the analyst's acceptance of the reality of dependence, and his working with it in the transference.[8]

It would seem that the study of ego defences takes the investigator back to pregenital id-manifestations, whereas the study of ego psychology takes him back to dependence, to the maternal-care–infant unit.

One half of the theory of the parent-infant relationship concerns the infant, and is the theory of the infant's journey from absolute dependence, through relative dependence, to independence, and, in parallel, the infant's journey from the pleasure principle to the reality principle, and from autoerotism to object relationships. The other half of the theory of the parent-infant relationship concerns maternal care, that is to say the qualities and changes in the mother that meet the specific and developing needs of the infant towards whom she orientates.

A. The Infant

The key word in this part of the study is *dependence*. Human infants cannot start to *be* except under certain conditions. These conditions are studied below, but they are part of the psychology of the infant. Infants come into *being* differently according to whether the conditions are favourable or unfavourable. At the same time conditions do not determine the infant's potential. This is inherited, and it is legitimate to study this inherited potential of the individual as a separate issue, *provided always that it is accepted that the inherited potential of an infant cannot become an infant unless linked to maternal care.*

The inherited potential includes a tendency towards growth and development. All stages of emotional growth can be roughly dated. Presumably all developmental stages have a date in each individual child. Nevertheless, not only do these dates vary from child to child, but also, *even if they were known in advance* in the case of a given child, they could not be used in predicting the child's actual development because of the other factor, maternal care. If such dates could be used in prediction at all, it would be on the basis of assuming a maternal care that is adequate in the important respects. (This obviously does not mean adequate only in the physical sense; the meaning of adequacy and inadequacy in this context is discussed below.)

The Inherited Potential and Its Fate

It is necessary here to attempt to state briefly what happens to the inherited potential if this is to develop into an infant, and thereafter into a child, a child reaching towards independent existence. Because of the complexities of the subject such a statement must be made on the assumption of satisfactory maternal care, which means parental care. Satisfactory parental care can be classified roughly into three overlapping stages:

(*a*) Holding.

(*b*) Mother and infant living together. Here the father's function (of dealing with the environment for the mother) is not known to the infant.

(*c*) Father, mother, and infant, all three living together.

The term ' holding ' is used here to denote not only the actual physical holding of the infant, but also the total environmental provision prior to the concept of *living with.* In other words, it refers to a three-dimensional or space relationship with time gradually added. This overlaps with, but is initiated prior to, instinctual experiences that in time would determine object relationships. It includes the management of experiences that are inherent in existence, such as the *completion* (and therefore the *non-completion*) of processes, processes which from the outside may seem to be purely physiological but which belong to infant psychology and take place in a complex psychological field, determined by the awareness and the empathy of the mother. (This concept of holding is further discussed below.)

The term ' living with ' implies object relationships, and the emergence of the infant from the state of being merged with the mother, or his perception of objects as external to the self.

This study is especially concerned with the ' holding ' stage of maternal care, and with the

[8] For a clinical example see (17).

complex events in infants' psychological development that are related to this holding phase. It should be remembered, however, that a division of one phase from another is artificial, and merely a matter of convenience, adopted for the purpose of clearer definition.

Infant Development During the Holding Phase

In the light of this some characteristics of infant development during this phase can be enumerated. It is at this stage that

primary process
primary identification
auto-erotism
primary narcissism

are living realities.

In this phase the ego changes over from an unintegrated state to a structured integration, and so the infant becomes able to experience anxiety associated with disintegration. The word disintegration begins to have a meaning which it did not possess before ego integration became a fact. In healthy development at this stage the infant retains the capacity for re-experiencing unintegrated states, but this depends on the continuation of reliable maternal care or on the build-up in the infant of memories of maternal care beginning gradually to be perceived as such. The result of healthy progress in the infant's development during this stage is that he attains to what might be called ' unit status '. The infant becomes a person, an individual in his own right.

Associated with this attainment is the infant's psychosomatic existence, which begins to take on a personal pattern; I have referred to this as the psyche indwelling in the soma.[9] The basis for this indwelling is a linkage of motor and sensory and functional experiences with the infant's new state of being a person. As a further development there comes into existence what might be called a limiting membrane, which to some extent (in health) is equated with the surface of the skin, and has a position between the infant's ' me ' and his ' not-me '. So the infant comes to have an inside and an outside, and a body-scheme. In this way meaning comes to the function of intake and output; moreover, it gradually becomes meaningful to postulate a personal or inner psychic reality for the infant.[10]

During the holding phase other processes are initiated; the most important is the dawn of intelligence and the beginning of a mind as something distinct from the psyche. From this follows the whole story of the secondary processes and of symbolic functioning, and of the organization of a personal psychic content, which forms a basis for dreaming and for living relationships.

At the same time there starts in the infant a joining up of two roots of impulsive behaviour. The term ' fusion ' indicates the positive process whereby diffuse elements that belong to movement and to muscle erotism become (in health) fused with the orgiastic functioning of the erotogenic zones. This concept is more familiar as the reverse process of defusion, which is a complicated defence in which aggression becomes separated out from erotic experience after a period in which a degree of fusion has been achieved. All these developments belong to the environmental condition of *holding*, and without a good enough holding these stages cannot be attained, or once attained cannot become established.

A further development is in the capacity for object relationships. Here the infant changes from a relationship to a subjectively conceived object to a relationship to an object objectively perceived. This change is closely bound up with the infant's change from being merged with the mother to being separate from her, or to relating to her as separate and ' not-me '. This development is not specifically related to the holding, but is related to the phase of ' living with '. . .

Dependence

In the holding phase the infant is maximally dependent. One can classify dependence thus:

(i) *Absolute Dependence.* In this state the infant has no means of knowing about the maternal care, which is largely a matter of prophylaxis. He cannot gain control over what is well and what is badly done, but is only in a position to gain profit or to suffer disturbance.

(ii) *Relative Dependence.* Here the infant can become aware of the need for the details of maternal care, and can to a growing extent relate them to personal impulse, and then later, in a psycho-analytic treatment, can reproduce them in the transference.

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[9] For an earlier statement by me on this issue see (13).

[10] Here the work on primitive fantasy, with whose richness and complexity we are familiar through the teachings of Melanie Klein, becomes applicable and appropriate.

(iii) *Towards Independence.* The infant develops means for doing without actual care. This is accomplished through the accumulation of memories of care, the projection of personal needs and the introjection of care details, with the development of confidence in the environment. Here must be added the element of intellectual understanding with its tremendous implications.

Isolation of the Individual

Another phenomenon that needs consideration at this phase is the hiding of the core of the personality. Let us examine the concept of a central or true self. The central self could be said to be the inherited potential which is experiencing a continuity of being, and acquiring in its own way and at its own speed a personal psychic reality and a personal body scheme.[11] It seems necessary to allow for the concept of the isolation of this central self as a characteristic of health. Any threat to this isolation of the true self constitutes a major anxiety at this early stage, and defences of earliest infancy appear in relation to failures on the part of the mother (or in maternal care) to ward off impingements which might disturb this isolation.

Impingements may be met and dealt with by the ego organization, gathered into the infant's omnipotence and sensed as projections.[12] On the other hand they may get through this defence in spite of the ego support which maternal care provides. Then the central core of the ego is affected, and this is the very nature of psychotic anxiety. In health the individual soon becomes invulnerable in this respect, and if external factors impinge there is merely a new degree and quality in the hiding of the central self. In this respect the best defence is the organization of a false self. Instinctual satisfactions and object relationships themselves constitute a threat to the individual's personal going-on-being. *Example:* a baby is feeding at the breast and obtains satisfaction. This fact by itself does not indicate whether he is having an ego-syntonic id experience or, on the contrary, is suffering the trauma of a seduction, a threat to personal ego continuity, a threat by an id experience which is not ego-syntonic, and with which the ego is not equipped to deal.

In health object relationships can be developed on the basis of a compromise, one which involves the individual in what later would be called cheating and dishonesty, whereas a direct relationship is possible only on the basis of regression to a state of being merged with the mother.

Annihilation[13]

Anxiety in these early stages of the parent-infant relationship relates to the threat of annihilation, and it is necessary to explain what is meant by this term.

In this phase which is characterized by the essential existence of a holding environment, the 'inherited potential' is becoming itself a 'continuity of being'. The alternative to being is reacting, and reacting interrupts being and annihilates. Being and annihilation are the two alternatives. The holding environment therefore has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being. Under favourable conditions the infant establishes a continuity of existence and then begins to develop the sophistications which make it possible for impingements to be gathered into the area of omnipotence. At this stage the word death has no possible application, and this makes the term death instinct unacceptable in describing the root of destructiveness. Death has no meaning until the arrival of hate and of the concept of the whole human person. When a whole human person can be hated, death has meaning, and close on this follows that which can be called maiming; the whole hated and loved person is kept alive by being castrated or otherwise maimed instead of killed. These ideas belong to a phase later than that characterized by dependence on the holding environment.

Freud's Footnote Re-examined

At this point it is necessary to look again at Freud's statement quoted earlier. He writes: 'Probably it (the baby) hallucinates the fulfilment of its inner needs; it betrays its pain due to increase of stimulation and delay of satisfaction by the motor discharge of crying and struggling, and then experiences the hallucinated satisfaction.' The theory indicated in this part of the

[11] In another paper (22) I have tried to discuss another aspect of this developmental phase as we see it in adult health. Cf. Greenacre (7).

[12] I am using the term 'projections' here in a descriptive and dynamic and not in its full metapsychological sense. The function of primitive psychic mechanisms, such as introjection, projection, and splitting, falls beyond the scope of this paper.

[13] I have described clinical varieties of this type of anxiety from a slightly different aspect in a previous paper (12).

statement fails to cover the requirements of the earliest phase. Already by these words reference is being made to object relationships, and the validity of this part of Freud's statement depends on his taking for granted the earlier aspects of maternal care, those which are here described as belonging to the holding phase. On the other hand, this sentence of Freud fits exactly the requirements in the next phase, that which is characterized by a relationship between infant and mother in which object relationships and instinctual or erotogenic-zone satisfactions hold sway; that is, when development proceeds well.

B. The Role of the Maternal Care

I shall now attempt to describe some aspects of maternal care, and especially holding. In this paper the concept of holding is important, and a further development of the idea is necessary. The word is here used to introduce a full development of the theme contained in Freud's phrase '. . . when one considers that the infant—provided one includes with it the care it receives from its mother—does almost realize a psychical system of this kind.' I refer to the actual state of the infant-mother relationship at the beginning when the infant has not separated out a self from the maternal care on which there exists absolute dependence in a psychological sense.[14]

At this stage the infant needs and in fact usually gets an environmental provision which has certain characteristics:

It meets physiological needs. Here physiology and psychology have not yet become distinct, or are only in the process of doing so; and

It is reliable. But the environmental provision is not mechanically so. It is reliable in a way that implies the mother's empathy.

Holding

Protects from physiological insult.

Takes account of the infant's skin sensitivity—touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling (action of gravity) and of the infant's lack of knowledge of the existence of anything other than the self.

It includes the whole routine of care throughout the day and night, and it is not the same with any two infants because it is part of the infant, and no two infants are alike.

Also it follows the minute day-to-day changes belonging to the infant's growth and development, both physical and psychological.

It should be noted that mothers who have it in them to provide good enough care can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of their task. Mothers who do not have it in them to provide good enough care cannot be made good enough by mere instruction.

Holding includes especially the physical holding of the infant, which is a form of loving. It is perhaps the only way in which a mother can show the infant her love of it. There are those who can hold an infant and those who cannot; the latter quickly produce in the infant a sense of insecurity, and distressed crying.

All this leads right up to, includes, and co-exists with the establishment of the infant's first object relationships and his first experiences of instinctual gratification.[15]

It would be wrong to put the instinctual gratification (feeding etc.) or object relationships (relation to the breast) before the matter of ego organization (i.e. infant ego reinforced by maternal ego). The basis for instinctual satisfaction and for object relationships is the handling and the general management and the care of the infant, which is only too easily taken for granted when all goes well.

The mental health of the individual, in the sense of freedom from psychosis or liability to psychosis (schizophrenia), is laid down by this maternal care, which when it goes well is scarcely noticed, and is a continuation of the physiological provision that characterizes the prenatal state. This environmental provision is also a continuation of the tissue aliveness and the functional health which (for the infant) provides silent but vitally important ego support. In this way schizophrenia or infantile psychosis or a liability to psychosis at a later date is related to a failure of environmental provision. This is not to say, however, that the ill effects of such failure cannot be described in terms of ego distortion and of the defences against primitive

[14] Reminder: to be sure of separating this off from object-relationships and instinct-gratification I must *artificially* confine my attention to the body needs of a general kind. A patient said to me: 'A good analytic hour in which the right interpretation is given at the right time *is* a good feed'.

[15] For further discussion of this aspect of the developmental processes see my paper (14).

anxieties, that is to say in terms of the individual. It will be seen, therefore, that the work of Klein on the splitting defence mechanisms and on projections and introjections and so on, is an attempt to state the effects of failure of environmental provision in terms of the individual. This work on primitive mechanisms gives the clue to only one part of the story, and a reconstruction of the environment and of its failures provides the other part. This other part cannot appear in the transference because of the patient's lack of knowledge of the maternal care, either in its good or in its failing aspects, as it existed in the original infantile setting.

Examination of One Detail of Maternal Care

I will give an example to illustrate subtlety in infant care. An infant is merged with the mother, and while this remains true the nearer the mother can come to an exact understanding of the infant's needs the better. A change, however, comes with the end of merging, and this end is not necessarily gradual. As soon as mother and infant are separate, from the infant's point of view, then it will be noted that the mother tends to change in her attitude. It is as if she now realizes that the infant no longer expects the condition in which there is an almost magical understanding of need. The mother seems to know that the infant has a new capacity, that of giving a signal so that she can be guided towards meeting the infant's needs. It could be said that if now she knows too well what the infant needs, this is magic and forms no basis for an object relationship. Here we get to Freud's words: 'It (the infant) probably hallucinates the fulfilment of its internal needs; it betrays its unpleasure, when there is an increase of stimulus and an absence of satisfaction, by the motor discharge of screaming and beating about with its arms and legs, and it then experiences the satisfaction it has hallucinated.' In other words, at the end of merging, when the child has become separate from the environment, an important feature is that the infant has to give a signal.[16] We find this subtlety appearing clearly in the transference in our analytic work. It is very important, except when the patient is regressed to earliest infancy and to a state of merging, that the analyst shall *not* know the answers except in so far as the patient gives the clues. The analyst gathers the clues and makes the interpretations, and it often happens that patients fail to give the clues, making certain thereby that the analyst can do nothing. This limitation of the analyst's power is important to the patient, just as the analyst's power is important, represented by the interpretation that is right and that is made at the right moment, and that is based on the clues and the unconscious co-operation of the patient who is supplying the material which builds up and justifies the interpretation. In this way the student analyst sometimes does better analysis than he will do in a few years' time when he knows more. When he has had several patients he begins to find it irksome to go as slowly as the patient is going, and he begins to make interpretations based not on material supplied on that particular day by the patient but on his own accumulated knowledge or his adherence for the time being to a particular group of ideas. This is of no use to the patient. The analyst may appear to be very clever, and the patient may express admiration, but in the end the correct interpretation is a trauma, which the patient has to reject, because it is not his. He complains that the analyst attempts to hypnotize him, that is to say, that the analyst is inviting a severe regression to dependence, pulling the patient back to a merging in with the analyst.

The same thing can be observed with the mothers of infants; mothers who have had several children begin to be so good at the technique of mothering that they do all the right things at the right moments, and then the infant who has begun to become separate from the mother has no means of gaining control of all the good things that are going on. The creative gesture, the cry, the protest, all the little signs that are supposed to produce what the mother does, all these things are missing, because the mother has already met the need just as if the infant were still merged with her and she with the infant. In this way the mother, by being a seemingly good mother, does something worse than castrate the infant. The latter is left with two alternatives; either being in a permanent state of regression and of being merged with the mother, or else staging a total rejection of the mother, even of the seemingly good mother.

We see therefore that in infancy and in the management of infants there is a very subtle distinction between the mother's understanding of her infant's need based on empathy, and her change over to an understanding based on

[16] Freud's later theory of anxiety as a signal to the ego (6).

something in the infant or small child that indicates need. This is particularly difficult for mothers because of the fact that children vacillate between one state and the other; one minute they are merged with their mothers and require empathy, while the next they are separate from her, and then if she knows their needs in advance she is dangerous, a witch. It is a very strange thing that mothers who are quite uninstructed adapt to these changes in their developing infants satisfactorily and without any knowledge of the theory. This detail is reproduced in psycho-analytic work with borderline cases, and in all cases at certain moments of great importance when dependence in transference is maximal.

Unawareness of Satisfactory Maternal Care

It is axiomatic in these matters of maternal care of the holding variety that when things go well the infant has no means of knowing what is being properly provided and what is being prevented. On the other hand it is when things do not go well that the infant becomes aware, not of the failure of maternal care, but of the results, whatever they may be, of that failure; that is to say, the infant becomes aware of reacting to some impingement. As a result of success in maternal care there is built up in the infant a continuity of being which is the basis of ego strength; whereas the result of each failure in maternal care is that the continuity of being is interrupted by reactions to the consequences of that failure, with resultant ego-weakening.[17] Such interruptions constitute annihilation, and are evidently associated with pain of psychotic quality and intensity. In the extreme case the infant exists only on the basis of a continuity of reactions to impingement and of recoveries from such reactions. This is in great contrast to the continuity of being which is my conception of ego strength.

C. The Changes in the Mother

It is important in this context to examine the changes that occur in women who are about to have a baby or who have just had one. These changes are at first almost physiological, and they start with the physical holding of the baby in the womb. Something would be missing, however, if a phrase such as ' maternal instinct ' were used in description. The fact is that in health women change in their orientation to themselves and to the world, but however deeply rooted in physiology such changes may be, they can be distorted by mental ill-health in the woman. It is necessary to think of these changes in psychological terms and this in spite of the fact that there may be endocrinological factors which can be affected by medication.

No doubt the physiological changes sensitize the woman to the more subtle psychological changes that follow.

Soon after conception, or when conception is known to be possible, the woman begins to alter in her orientation, and to be concerned with the changes that are taking place within her. In various ways she is encouraged by her own body to be interested in herself.[18] The mother shifts some of her sense of self on to the baby that is growing within her. The important thing is that there comes into existence a state of affairs that merits description and the theory of which needs to be worked out.

The analyst who is meeting the needs of a patient who is reliving these very early stages in the transference undergoes similar changes of orientation; and the analyst, unlike the mother, needs to be aware of the sensitivity which develops in him or her in response to the patient's immaturity and dependence. This could be thought of as an extension of Freud's description of the analyst as being in a voluntary state of attentiveness.

A detailed description of the changes in orientation in a woman who is becoming or who has just become a mother would be out of place here, and I have made an attempt elsewhere to describe these changes in popular or non-technical language (23).

There is a psychopathology of these changes in orientation, and the extremes of abnormality are the concern of those who study the psychology of puerperal insanity. No doubt there are many variations in quality which do not constitute abnormality. It is the degree of distortion that constitutes abnormality.

By and large mothers do in one way or an-

[17] In character cases it is this ego-weakening and the individual's various attempts to deal with it that presents itself for immediate attention, and yet only a true view of the etiology can make possible a sorting out of the defence aspect of this presenting symptom from its origin in environmental failure. I have referred to one specific aspect of this in the diagnosis of the antisocial tendency as the basic problem behind the Delinquency Syndrome (19).

[18] For a more detailed statement on this point see: ' Primary Maternal Preoccupation ' (20).

other identify themselves with the baby that is growing within them, and in this way they achieve a very powerful sense of what the baby needs. This is a projective identification. This identification with the baby lasts for a certain length of time after parturition, and then gradually loses significance.

In the ordinary case the mother's special orientation to the infant carries over beyond the birth process. The mother who is not distorted in these matters is ready to let go of her identification with the infant as the infant needs to become separate. It is possible to provide good initial care, but to fail to complete the process through an inability to let it come to an end, so that the mother tends to remain merged with her infant and to delay the infant's separation from her. It is in any case a difficult thing for a mother to separate from her infant at the same speed at which the infant needs to become separate from her.[19]

The important thing, in my view, is that the mother through identification of herself with her infant knows what the infant feels like and so is able to provide almost exactly what the infant needs in the way of holding and in the provision of an environment generally. Without such an identification I consider that she is not able to provide what the infant needs at the beginning, which is *a live adaptation to the infant's needs.* The main thing is the physical holding, and this is the basis of all the more complex aspects of holding, and of environmental provision in general.

It is true that a mother may have a baby who is very different from herself so that she miscalculates. The baby may be quicker or slower than she is, and so on. In this way there may be times when what she feels the baby needs is not in fact correct. However, it seems to be usual that mothers who are not distorted by ill-health or by present-day environmental stress do tend on the whole to know what their infants need accurately enough, and further, they like to provide what is needed. This is the essence of maternal care.

With ' the care that it receives from its mother ' each infant is able to have a personal existence, and so begins to build up what might be called *a continuity of being.* On the basis of this continuity of being the inherited potential gradually develops into an individual infant. If maternal care is not good enough then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement.

All this has significance for the analyst. Indeed it is not from direct observation of infants so much as from the study of the transference in the analytic setting that it is possible to gain a clear view of what takes place in infancy itself. This work on infantile dependence derives from the study of the transference and counter-transference phenomena that belong to the psycho-analyst's involvement with the borderline case. In my opinion this involvement is a legitimate extension of psycho-analysis, the only real alteration being in the diagnosis of the illness of the patient, the etiology of whose illness goes back behind the Oedipus complex, and involves a distortion at the time of absolute dependence.

Freud was able to discover infantile sexuality in a new way because he reconstructed it from his analytic work with psycho-neurotic patients. In extending his work to cover the treatment of the borderline psychotic patient it is possible for us to reconstruct the dynamics of infancy and of infantile dependence, and of the maternal care that meets this dependence.

Summary

(i) An examination is made of infancy; this is not the same as an examination of primitive mental mechanisms.

(ii) The main feature of infancy is dependence; this is discussed in terms of the holding environment.

(iii) Any study of infancy must be divided into two parts:

(*a*) Infant development facilitated by good-enough maternal care;

(*b*) Infant development distorted by maternal care that is not good enough.

(iv) The infant ego can be said to be weak, but in fact is strong because of the ego support of maternal care. Where maternal care fails the weakness of the infant ego becomes apparent.

(v) Processes in the mother (and in the father) bring about, in health, a special state in which the parent is orientated to the infant, and is thus in a position to meet the infant's dependence. There is a pathology of these processes.

[19] Case-material to illustrate one type of problem that is met with clinically and relates to this group of ideas is presented in an earlier paper (11).

(vi) Attention is drawn to the various ways in which these conditions inherent in what is here termed the holding environment can or cannot appear in the transference if at a later date the infant should come into analysis.

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A THIRD CONTRIBUTION TO THE STUDY OF SLIPS OF THE TONGUE

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In my first paper on slips of the tongue (1), published in 1936, I expressed the view that in studying this subject we should not neglect the so-called intention interfered with because, in addition to its conscious harmless meaning, this intention is tinged with an unconscious prohibited quality. I described the mechanism of slips of the tongue in these words:

'A phrase or a word which should have been pronounced has not only a conscious but also an unconscious significance, the latter representing the gratification of an infantile instinctual wish. This wish belongs to the id and the unconscious part of the ego takes up a defence to prevent it from being satisfied. The defence is a twofold process: (*a*) The instinct fusion which is pressing for a gratification is turned against the self; (*b*) the opposite type of instinct fusion is mobilized.'

Despite the fact that Freud (8) accepted my criticism of his original explanation and agreed with me that slips of the tongue should be regarded not as a break-through of an infantile wish but rather as a defence against such a wish, the distinction I made has received only limited recognition.

My second contribution to the subject (2) dealt with the problem of the narcissistic mortification present in slips of the tongue. In the present paper I shall try to use slips of the tongue in examining the pleasure-unpleasure principle as manifested in their formation.

According to Freud, two goals dominate our life, acquiring pleasure and eliminating unpleasure. The fact that in many actions both goals are pursued at one and the same time does not mean that we cannot for psycho-analytic purposes separate the two. Originally Freud expressed the opinion that pleasure increases while tension is being discharged. Subsequently he corrected his statement, pointing out that the examination of pleasure present in sexual intercourse shows that under certain conditions pleasure increases while we undergo an increase of tension.

Revising his original formulation, Freud said that we have to differentiate between two kinds of pleasure: that which is present while our tension increases, and that wherein we experience a decrease of tension and finally a disappearance of pleasure. He went on to say that the pleasure connected with an increase of tension is produced by stimulation of erotogenic zones, and he called it forepleasure. Endpleasure was the term he reserved for that which is felt while tension is being discharged.

In previous papers I expressed the opinion that so-called forepleasure, namely that connected with an increase of tension, may be experienced *without* stimulation of erotogenic zones. Moreover, I held that the anticipation of a final discharge of tension produces under certain circumstances a sensation of forepleasure. Only if we anticipate the final genital discharge does the stimulation of erotogenic zones produce forepleasure. I also suggested that forepleasure can be experienced in the infantile stages of development (5).

Today, on the basis of additional observations, I have the impression that the experience of forepleasure, which Freud maintained is always a conscious one taking place in the ego or perhaps in the total personality, is always connected with and indeed only possible where there is experience of instinctual tension and simultaneous anticipation of a final discharge of this tension in the near future.

Like hunger or thirst, the experience of unpleasure appears to be the result of an accumulation or disappearance of certain metabolites which were either accumulated in excess or used up. This experience of unpleasure can be eliminated if the original balance of metabolites is restored by incorporating or eliminat-

ing certain metabolites. I would call such an elimination of unpleasure an *instinctual satisfaction.* It may be accomplished by the actions either of the subject or the object or both. For instance, a child eats, or the mother feeds the child.

Pleasure (fore- and endpleasure) appears to be a kind of premium we learn to experience, provided we accept for a certain time the unpleasure of instinctual tension and then proceed to eliminate this tension by finding an object pleasing to our senses and setting in motion the kind of muscular activity required to obtain this object.

Separating the concept of pleasure from that of satisfaction, we can no longer assume that a patient in his neurosis experiences pleasure which he is unaware of, yet which, according to Freud, may not be described as unconscious. Instead, we may say that whenever a patient has some decrease of tension with the help of his symptom or his neurotic character trait he experiences an instinctual satisfaction.

As previously mentioned, during the experience of forepleasure our instinctual tension increases. I should like to suggest that the phenomenon of pleasure be divided into three categories: (i) Pleasure which we experience when anticipating a final discharge of the tension we feel. Such pleasure might be termed ' anticipated pleasure '. (ii) Pleasure which takes place as a result of the stimulation of our senses by a pleasing object—' sensuous pleasure '. (iii) Pleasure when we gain the pleasing object—' endpleasure '. This kind of pleasure, as previously mentioned, disappears with the beginning of the instinctual discharge. When we are hungry and anticipate partaking of a tasty meal, we experience anticipated pleasure. This turns into sensuous pleasure when a delectable dish is set before us and we can see it and inhale the appetizing odours. The moment we begin to eat, we are having endpleasure, which gradually fades as the food is consumed. Finally, as the food is being digested, the instinctual tension disappears and there is instinctual satisfaction.

Conscious experience of pleasure and unpleasure probably does not take place *in utero* (4), but appears only after birth. The embryo may suffer some kind of discomfort, but the reflexes present at this stage of development are usually able to deal with it. There is no reason to suppose that the embryo experiences a conscious sensation of unpleasure which the newborn infant discovers, for instance, as a result of the lack of oxygen.

In the oral stage a newborn child experiences unpleasure caused by hunger and thirst and on being fed by his mother he feels instinctual satisfaction. One day he discovers something new, namely pleasure. From this it appears that the phenomenon of pleasure is based on the following factors:

First, the individual must experience a conscious unpleasure as a result of an increased instinctual tension that passed its threshold. Second, he has to learn that wishing alone does not lead to instinctual satisfaction. The fact that wishing to obtain gratification does not produce gratification but only increases the tension of the hunger responsible for this wish leads to the recognition that wishing is not suitable for eliminating instinctual tension, and that an act of the child or the mother or both is required.

Later, the child begins to remember that in the past he succeeded in getting rid of hunger with the help of milk supplied by his mother, and in his fantasy he will anticipate the getting of milk. Thus he experiences a new sensation, namely that of anticipated pleasure. If he is offered the breast and sees, tastes, and smells the milk, this anticipated pleasure will change until it becomes endpleasure. Finally, after the milk is swallowed and begins to be digested, the child will experience an instinctual satisfaction. Here, then, is an example of an instinctual satisfaction and of anticipated, sensuous endpleasure. The child learns that in order to eliminate the unpleasure he suffers from he has to act, to find the object he needs, and to use it.

The sensation of pleasure comes about only if the elimination of pleasure proceeds along certain lines. The object used for this purpose must be acceptable to the total personality of the individual, and he must be able for a time to tolerate a certain amount of unpleasure caused by instinctual tension. It seems, too, that with the help of his symptoms the neurotic obtains only instinctual discharge and not pleasure (in this he differs from a pervert). Moreover, the neurotic, unwilling to face the natural limitations of his power, is able with the help of his neurosis to entertain the illusion of being omnipotent. In his analysis he will have to suffer unpleasure before he is able to experience pleasure.

It appears that in addition to the energy responsible for the gratification of our basic needs a certain amount of libido and destrudo

cathects our sense organs.[1] If that is the case, we may say that the stimulation of the sense organs leads to a discharge of the energy which cathects them. The sensation of pleasure now appears to be a very complicated phenomenon. It depends on our ability to tolerate unpleasure caused by the dammed-up energy associated with our basic needs and on our ability to find a suitable object, execute the necessary steps, and transform part of our energy into that connected with the senses (sensuous energy).

In addition to the unpleasure caused by increased instinctual tension, there is another kind which occurs whenever an external or internal power overwhelms us and forces us to accept something we resent. I have suggested that what we feel while we are being overwhelmed might be called narcissistic mortification (6).

The term ' external narcissistic mortification ' is applicable whenever an external aggressor is present and the term ' internal narcissistic mortification ' indicates that a part of us has succeeded in overwhelming us.[2]

Consequently, two kinds of unpleasure have to be distinguished: (*a*) unpleasure due to increased instinctual tension above a certain threshold; (*b*) unpleasure caused by being overwhelmed by an internal or external aggressor. It is obvious that unpleasure due to increased instinctual tension can be eliminated only by the incorporation or evacuation of certain metabolites, as has been previously mentioned, while the unpleasure due to narcissistic mortification can be disposed of when we succeed in repeating in an active manner what happened passively to us and so injure the aggressor. In this way the narcissistic mortification forces the individual to inflict another narcissistic mortification on somebody else or upon himself. A clear understanding and a clear differentiation of these two kinds of unpleasure and the methods of dealing with them are important, because the patient is unaware of what kind of unpleasure he suffered and therefore unable to find the proper method of eliminating it.[3]

It may be useful to illustrate this point with the following example of a slip of the tongue. A patient whom I had analyzed for many months told me that when he entered a restaurant with a girl he called ' Miss Forepleasure ' he made the following slip. Wanting to ask the head waiter for a table, he said, ' Do you have a room? ' The patient at once understood the meaning of his slip and grew embarrassed because it was obvious to him and also to the waiter and to his girl-friend that he was so anxious to go to bed with her that instead of asking for a table he had asked for a room.

In analyzing this slip of the tongue I tried at first to get additional material connected with the word ' room ' which, according to Freud, represents a harmful unconscious tendency with the power to break through and appear in our conscious. Often, a slip of the tongue does not make sense unless we analyze it with the help of the patient's associations.

Sometimes however, as in this case, the hidden meaning of the so-called harmful tendency is obvious without further examination, but in order to obtain a more exact evaluation of the patient's defences his associations should not be neglected. In this instance, his associations showed that he was preoccupied with the idea of going to bed with his girl-friend and considered it a waste of time to dine first. Further associations indicated that this slip represented a punishment because in admitting what he wanted in public he had to accept a certain amount of embarrassment.

Further, I thought we ought to find out why the word ' table ' was omitted, although Freud originally said that the omitted word represents a harmless conscious tendency and does not require further analysis. From the associations of the patient it became obvious that eating had an infantile meaning for him, and that he and his unconscious wanted to be forced to feed and to watch his girl-friend.

Rather than representing a harmless tendency, it became more and more evident that the word ' table ' had to be omitted because it would have been used for the infantile gratification of a repressed oral, aggressive, and scoptophilic wish connected with identification with the preoedipal mother. The material gained in analyzing why the word ' room ' was used instead of the word ' table ' showed that ' table ' represented an unconscious defence of this oral wish.

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[1] This libido represents perhaps the first qualitative change of our instinctual energy in our attempt to sublimate.

[2] Pain appears to be a sensation related to that of unpleasure but not identical with it. Under certain conditions the unpleasure of hunger changes into pain. It would seem that the sensation of pain is closer to the experience of narcissistic mortification than to the unpleasure of a dammed-up instinctual energy.

[3] Anticipation of a narcissistic mortification produces fear, and elimination of a narcissistic mortification leads to narcissistic gratification.

While it is true that the word ' room ' expressed phallic and exhibitionistic desires, ' table ' represented at the same time something more dangerous—namely, the wish to be a wet nurse and be forced to feed Miss Forepleasure. The analysis of the unconscious meaning of the words involved (after the resistance had been overcome) disclosed the presence of infantile wishes and the defence of mobilizing other infantile wishes which were used as counter cathexis.

In addition we found that this slip of the tongue was used to avoid the consciousness of a certain narcissistic mortification—the girl's having the power to force my patient to feed her. The fact that as a child he had not had such power, and had experienced a severe narcissistic mortification because his mother was able to control his eating habits, was responsible for the repression of his oral wishes.

The external narcissistic mortification, ' She can force me to give her food, whereas I had to wait for my mother,' was something the patient had to avoid, and therefore the word ' table ' which represented this narcissistic mortification had to be omitted. At the same time the word ' room ' represented another kind of narcissistic mortification which became conscious by his slip of the tongue. This internal narcissistic mortification was caused by the power of his phallic desires forcing him to give expression to them, and acceptance of it was used to cover up the external narcissistic mortification connected with the unconscious wish to be forced to feed his girl-friend.

Apparently, the use of the word ' table ' which the patient avoided would have produced some kind of infantile unpleasure connected with an oral tension. The patient tried to eliminate this kind of unpleasure by mobilizing another kind linked with the damming up of phallic wishes. This unpleasure was partly eliminated by his saying, ' Do you have a room?' In addition, the unpleasure tied up with his inability to control his wish to be forced to feed was eliminated by his accepting instead the inability to control what he wanted to say to the head waiter.

Consciously, the patient resented his slip of the tongue because it produced a conscious internal narcissistic mortification. He had to admit that part of his personality (the patient referred to this part as ' my evil tongue ') had the power to distort what he wanted to say to the head waiter. This sensation of unpleasure due to his inability to control his speech was compounded when he recognized that the word ' room ' was a public confession of his desire to go to bed with the girl. By the slip of the tongue the unpleasure caused by the damming up of phallic wishes was partly eliminated through the verbal channel.

In other words, the word ' room ' produced the following effects: (*a*) unpleasure because of the internal narcissistic mortification; (*b*) unpleasure connected with the humiliation of a public admission; (*c*) elimination of an unconscious feeling of guilt by substituting the punishment of public confession; (*d*) satisfaction because of a partial discharge of the phallic exhibitionistic wishes.

To reiterate, by eliminating the word ' table ' the patient avoided the unpleasure from the damming up of oral aggressive and scoptophilic wishes, and the unpleasure of an external narcissistic mortification. Although the intensity of the unpleasure or of an instinctual satisfaction the patient avoided or experienced by the slip of the tongue cannot very well be measured, it seems obvious that this patient or his unconscious was ready to accept the unpleasure and the partial gratification connected with the word ' room ' instead of the unpleasure and the partial gratification related to the word ' table'.

Evaluation of the resistance encountered in the interpretation of this slip led to the conclusion that for this patient the external narcissistic mortification was more dangerous than the internal one. Besides, it was more important for him to keep the oral aggressive and scoptophilic wishes repressed and instead to discharge the sexual phallic and exhibitionistic wishes.

At this point it must be admitted that while the analysis of a slip of the tongue has served as an illustration of the concept of unpleasure and that of instinctural satisfaction, it does not show the nature of pleasure. This comes as no surprise because we know that slips of the tongue, in spite of the fact that they represent an attempt to gratify infantile wishes, do not produce pleasure. A discharge of instinctual energy leads to pleasure, as has been previously noted, only if its form and object are acceptable to the total personality.

In order to study the sensation of pleasure we turn our attention to the dynamics associated with the laughter that is produced on listening to and understanding a joke. According to Freud, in addition to the forepleasure experienced as a result of the stimulation of erotogenic zones, there is another forepleasure,

psychic forepleasure, connected with a joke. Elsewhere (3) I have expressed the opinion that the pleasure of hearing a joke belongs to the category of aesthetic pleasure and has the character of endpleasure. While the forepleasure we feel whenever we anticipate a final discharge of our instinctual tension turns into unpleasure if such discharge is not forthcoming, aesthetic pleasure seems to be independent of any eventuality. A man who becomes excited while viewing a painting of a nude and tries to obtain the model's telephone number so that he can discharge his instinctual tension will obviously not be satisfied with aesthetic pleasure.

It appears that aesthetic pleasure is what we feel when we are able to perceive and enjoy a given object, without actually taking possession of it to gratify our instinctual needs. While it is true that aesthetic pleasure is no substitute for the pleasure connected with satisfying such basic needs, the very ability to have aesthetic pleasure makes us somewhat less dependent upon the external world.

I agree with Freud that aesthetic pleasure depends more on the form of what is experienced than its content, but I do not think aesthetic pleasure ought to be called forepleasure. The concept of forepleasure implies an expectation of unpleasure following close on its heels. As far as gratification of our basic needs is concerned, the experience of forepleasure turns into the unpleasure of frustration if the actual possession of the object is impossible. Aesthetic pleasure, as we have noted, does not require the possession of the object and therefore does not turn into the unpleasure of frustration even though the object has not been acquired.

To return to the previously described slip of the tongue, let us suppose that what the patient said was a deliberate jest on his part. About to ask for a table, let us say he became aware that what he really wanted far more than that was a bed. Instead of merely suppressing this wish as improper, he pretended to make a slip of the tongue, expressing in this disguise his real intentions. Obviously, he did not want to announce bluntly, 'Let's not waste time by eating'. Instead he decided to use his impatience by making fun of it and playing a little joke on himself. By pretending to be embarrassed by his use of the word 'room' and immediately correcting himself by saying 'table', he indicated that he did not approve of such a pointed demand, but was willing to expose it in order to be humorous.

The sequence of events is as follows: the patient's original wish to get a table was interfered with by another wish to get a room. This was then rejected, but instead of returning to his original wish for a table, he decided to turn it all into a joke. Thus the original wish to eat and the subsequent urge to go to bed instead were both abandoned for the sake of gaining the attention and admiration of the head waiter and the girl by making them laugh. The gratification of this third wish was possible because he succeeded in finding a humorous way of expressing the situation.

Now going on the assumption that his listeners did laugh, let us inquire what caused this laughter. Certainly, although it was a sign that the listener got the joke and enjoyed it (3) it could not have been caused simply by the confession of the desire to go to bed instead of having dinner. One might voice such a wish without anyone's laughing.

In order to find out what produced the laughter we have to examine not only the content but the particular *form* in which this joke was expressed. Had my patient said 'I wish we had a room' or 'Instead of wasting our time, let's take a room,' he may have been considered passionate or blunt but not amusing. It seems that his pretending to make a slip of the tongue not only showed what was in his mind but at the same time indicated that he was trying to detach himself from that urge by way of a short cut to happiness. Of course that idea in itself is not funny, expressed in so many words. A joke requires not only concentrated and compact presentation but also an unfinished text which the listener has to fill in. A joke loses its value unless we permit the listener to participate by guessing the basic idea.

In this case there was laughter because the listeners understood that the fake slip of the tongue meant not only 'I would rather go to bed' but also 'I am embarrassed that such an idea occurred to me'. Obviously, these thoughts if plainly stated would not be considered humorous. Apparently, a joke must express its point in a double meaning, and the simultaneous presence of the two meanings appears to be the *conditio sine qua non*.[4] The manifest

[4] Something of a similar split takes place in the theatre. While we watch the villain on the stage pursuing the hero, we are scared that the hero will be killed, but we don't shout for help (of course the primitive or the child does). On the other hand, if our neighbour collapses we spring to his side to help him.

meaning of the joke in question is not responsible for the laugh. Only if he understands the message implicit in the word ' room ' will he experience pleasure.

The wish to have a room comes from the unconscious, and although it becomes conscious without analysis of the usual resistance separating conscious from unconscious, I would not regard this wish as coming from the preconscious. According to Freud, material from the preconscious is always available to the conscious, while in the joke only under certain conditions and after overcoming some slight resistance do we get the hidden meaning. The best proof of this is the fact that when we hear a joke for the second time and its hidden meaning is already stored in our preconscious we do not laugh.

In making a joke we play with words. It is an excursion into the realm of make-believe, where for a short time the serious approach that insists upon knowing exactly what is what is abandoned.

It cannot be denied that one may fail to put this kind of joke across even if the listeners in question have a sense of humour and understand the double meaning. The listener who is himself very eager either to get a table or take a room may not be in the proper mood to appreciate this joke. A joke permits us to detach ourselves from reality, but this is not possible if the internal and external pressures of dammed-up basic needs are overwhelming.

In short, it appears that a witty man may make such a joke provided he is not too hungry (for room and board) and can obtain pleasure from his ability to find a form that offers immediate pleasure without need for action. It seems that Freud used the term forepleasure for the pleasure in humour because, like the forepleasure connected with our basic needs, it requires neither action nor possession of the object involved. This pleasure depends on our ability to think quickly and find ' le mot juste '.

Freud said that to the infant thinking and acting are one and the same, and, according to Ferenczi, one stage in this infantile omnipotence is characterized by the notion that talking has this magic power. The normal adult has to try to give up his omnipotence, but in dreams or slips of the tongue this illusion persists, and with the help of a joke is given full play and legitimately enjoyed. It goes without saying that not all words have this magic power, and the creation of a joke is not always easy, though it is only made of words.

Freud was of the opinion that the act of saving the energy which was prepared to be used is the hidden source of pleasure in wit. There is little doubt that such a saving takes place, but sometimes it may lead to an anticlimax and fail to produce laughter. It seems to me that the overcoming of a narcissistic mortification is more important than the saving of energy. The patient who makes a slip avoids the consciousness of an external narcissistic mortification and accepts an internal narcissistic mortification. The person who makes a joke, however, is conscious of the fact that he has to take his girl to dinner and recognizes that he would rather go to bed with her. Suddenly the inspiration comes to him that by pretending a slip of the tongue he may make her laugh.

The man who is able to make a joke uses it to free himself from a conflict, in this case between his wish to dine and his wish to go to bed with his girl-friend. He accepts the frustration of both wishes in order to obtain a gratification of his sublimated exhibitionistic wishes. In addition, by pretending he has made a slip he avoids being overwhelmed by it. He prefers making fun of himself to having others make fun of him (7). It is possible that what impresses us as comical was originally not intended to be so.

To recapitulate, the ability of the joker to make such a joke cannot be used instead of gratification of his oral and genital wishes. Nor can his sense of humour overcome the normal limitation of his power. But if he is able to detach himself from external and internal reality, he may briefly find aesthetic pleasure in the functioning of his mental apparatus. While it is true that everyone can obtain forepleasure from this function while anticipating an instinctual gratification, after a time this forepleasure will become unpleasure unless the possession of the pleasing object takes place.

Aesthetic pleasure, as we have noted, does not require possession of the object, and endpleasure is experienced when we succeed in making the listener laugh. We might say that the aesthetic pleasure felt by the creator of the joke before he tells it has the character of forepleasure. If this assumption is correct, then it has to be admitted that in a sense aesthetic endpleasure does require an external object (the audience) and some action (the laughter of the audience).

Generally speaking, a joke or a witty remark received in silence changes the forepleasure of the creator of the joke into unpleasure. As for

the listener, he derives aesthetic pleasure from understanding the hidden meaning of the joke, and his pleasure turns into endpleasure when he laughs (9). The pleasure in this case is caused not simply by a double meaning but by our ability to guess the second meaning. The discovery of the secret meaning of a joke may be considered a form of *peeking*. Understanding the hidden meaning is not a purely intellectual exercise. It mobilizes emotions that seem to originate in the unconscious. The word ' peeking ' indicates that in this case looking or watching is not used for examining external reality but to defy infantile prohibitions and obtain infantile sexual and aggressive pleasure.

Now the question arises, why does one man with a spark of inspiration make a joke, while another makes a slip of the tongue? Why is one individual able to face his wishes and the limitations of his power, while another has to deny them? It would be simple to say that the man who makes a slip deals with repressed infantile wishes, and the one who makes a joke has sublimated his infantile wishes and is free of unconscious complications. However, in my opinion this is far from correct. The fact that the listener must overcome a resistance while penetrating the veil that separates the latent from the manifest content, the quality of the emotion experienced, the fact that no such emotion takes place merely on grasping a double meaning—all these indicate that the material used in a joke resembles the material present in neuroses.

Freud pointed out that ideas which analysts discovered only after tedious work with their patients, artists obtained by sheer dint of inspiration. This is not to suggest that understanding or making a joke makes analysis unnecessary. In a joke the truth is accepted playfully despite the warning that there is always a grain of truth in a jest. A joke may produce laughter but not a cure. Nevertheless, a cured patient may sometimes laugh about his infantile troubles.

As previously mentioned, the wish appearing in the joke does not represent an arrival from the preconscious, but is probably a repressed infantile wish. I am in agreement with those analysts who have the impression that an infantile wish can be recognized as such by five characteristics: (i) the object represents an infantile figure (father, mother, and the like); (ii) the aim corresponds with one of the three stages (oral, anal, phallic); (iii) the gratification is accomplished by wishing alone; (iv) the aggression is mixed with sex (attraction of the forbidden); (v) the patient plays two roles (subject and object).

So far as the analysis of the slip of the tongue is concerned, there is no doubt in my mind that the wish responsible for it is infantile in nature. As to the analysis of the joke, by using material from patients who actually made jokes in analysis I am under the impression that the wishes responsible for a joke represent a mixture of sex and aggression and the objects are figures from childhood, but there is some doubt in my mind as to whether in a joke the person who tells the joke plays two roles.

If I am on the right track and the material present in the joke is similar to that of a slip, then it must be admitted that we really do not know why in one case a joke is made, and in another a slip of the tongue occurs. It may well be that the quantity of repressed energy is responsible for this difference, plus inherited factors that make one man witty and another dull.

Summary

1. Two basic forms of unpleasure are described: (*a*) unpleasure caused by damming up of instinctual energy; (*b*) unpleasure due to a narcissistic mortification. Some individuals suffer more from the one unpleasure than the other.

2. A discharge of instinctual tension and the elimination of unpleasure caused by damming up of instinctual energy does not necessarily produce pleasure, but results in instinctual gratification.

3. In order to experience pleasure, the instinctual energy must be discharged with the help of an object ' pleasing to the total personality ' and in a form approved by it.

4. The anticipation of a pleasurable discharge produces anticipated pleasure.

5. Sensory perception of the pleasing object produces sensuous pleasure.

6. Possession of a pleasing object leads to the sensation of endpleasure and the subsequent discharge of tension produces only an instinctual gratification.

7. The term forepleasure may be used to indicate anticipated pleasure, and pleasure from stimulation of our senses before the possession or control of the object takes place.

8. The sudden experience of a narcissistic mortification produces a feeling of terror.

9. Elimination of a narcissistic mortification with the help of an object and in a way pleasing to our total personality produces aggressive pleasure.

10. Elimination of a narcissistic mortification by a means or object not pleasing to the total personality leads to narcissistic gratification.

11. Some of us have the impression that a prolonged lack of external and internal stimuli produces the unpleasure of boredom and that too many 'pleasant' stimuli may lead to the unpleasure of exhaustion.

12. The anticipation of a narcissistic mortification produces fear.

13. The word 'room' used by this patient meant: (*a*) partial gratification of aggressive, exhibitionistic, and phallic wishes; (*b*) acceptance of an internal narcissistic mortification. The word 'table' represented: (*a*) oral scoptophilic sexual wishes; (*b*) an external narcissistic mortification.

14. A slip of the tongue is transformed into a joke by supposing that the patient only pretended to make a slip in order to arouse laughter.

15. In such a case it is assumed he must have known before he spoke the word 'room' that his wish to dine was being interfered with by another wish to to go bed with his girl-friend, and he accepted a temporary frustration of both wishes and detached himself from them in search of fun, succeeding in making his listeners laugh. Sometimes this detachment is so great that the joker takes the risk of provoking a punishment in order to make a humorous remark.

16. The man who makes a joke experiences anticipated pleasure when the funny idea occurs to him and endpleasure when he evokes laughter.

17. Like the pleasure experienced in connexion with a work of art, the pleasure derived by the joker is aesthetic. It is the result of sublimated instinctual energy chiefly scoptophilic in character which is fully discharged by the reaction of the audience. It requires an inner identification between the man who makes the joke and the listener. It depends more on the form than on the content.

18. This pleasure can be experienced not instead of but in addition to the pleasure derived from gratification of our basic needs.

19. It is probable that what has been illustrated by this joke applies to other jokes and represents a specific form of aesthetic pleasure.

20. The joker experiences endpleasure as a result of two factors: (i) he controls the object (the listener whom he made to laugh); and (ii) he vicariously enjoys the motor discharge of his audience (the laughter of the listener).

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TYPICAL ANXIETY DREAMS AND OBJECT RELATIONS

By

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I. Introduction

Since their first mention by Freud, the typical anxiety dreams have received little systematic attention from psycho-analytic investigators. This dearth of attention is somewhat surprising inasmuch as Freud stated that these dreams were worthy of further study, that because of their rather invariable manifest content their unconscious meaning might be understood without recourse to the dreamer's associations, and inasmuch as Freud's first exposition of the important oedipal complex derived from one such typical anxiety dream, that of the death of the beloved person (9). In this paper my main endeavour is, as in previous papers, to draw attention to the possible import of the two most commonly reported typical anxiety dreams. Whereas in the earlier papers clues to this import were derived from diagnostic material, they are here presented principally from treatment material obtained from 57 patients who have undergone psycho-analysis and psychotherapy with me in the past ten years.

In the previous papers (11) I wrote about the typical anxiety dreams as follows:

(i) In large samples of ' normal ' and emotionally disturbed adults and children, the two kinds of typical anxiety dreams reported as most unpleasant were: (*a*) dreams of falling from some height (hereafter referred to as the falling dream) and (*b*) dreams of being attacked, chased, or threatened by some object in the environment (hereinafter referred to as the attacked dream).

(ii) There were individual differences as to whether the person reported having had one dream or the other and, if he had had both, as to which dream was the more unpleasant.

Of the two dreams, the attacked dream has been described and discussed in psycho-analytic literature much more than has the falling dream. Its relation to the conflicts of the oedipal phase has been pointed out by Jones (14), Sperling (16), and others. In contrast, the falling dream has been scantily dealt with. Although Freud suggested that it reflected muscle erotism and a moral fall, he did not study it systematically. This may be due to the fact that he never had a dream of this type. For it was only of the falling dream that he explicitly commented, ' I have no experience of my own of other kinds of typical dreams, in which the dreamer finds himself flying through the air to the accompaniment of agreeable feelings or falling with feelings of anxiety ' (9, p. 271).

Although the attacked dream is much more frequently reported in the literature (and by my patients prior to treatment), this is not the case among the general population. In 3,000 inductees—a rough sample of the ' normal ' male population—38 per cent reported it as the most unpleasant dream, whereas 42 per cent reported the falling dream as such. (Most of the remaining 20 per cent denied having had either type of dream.) The falling dream therefore does not appear to be insignificant in reported occurrences or unpleasantness. It was this consideration which excited my interest as to why the falling dream—the extreme of which was frightening motion in the absence of a supporting object—should be predominantly unpleasant for a large number of people, whereas the attacked dream—the extreme of which was frightening paralysis in the face of external threat—should be predominantly unpleasant for an equally large number.

The present paper represents a continuation of this interest. The 57 patients previously mentioned are made up of a majority group of 41 for whom the attacked dream was predominantly unpleasant and a minority group of 16 for whom the falling dream was such. The methods of eliciting the predominant unpleasantness of past anxiety dreams have been stated elsewhere. Briefly, they consist of asking the subject to designate which is the most unpleasant of the

anxiety dreams he has spontaneously reported or has admitted to on direct questioning. It should be emphasized that my focus on the general dream meaning and on the manifest content does not represent a minimizing of the importance of the specific dream meaning or of the latent content. Instead, it represents a supplementary approach to the study of the dream.

At this point a sketch of pertinent theoretical concepts seems appropriate. In an earlier paper I suggested that the falling dream was reflective of separation anxiety and of the developmental period in which such psychic regulators as the superego and the ego-ideal resided not so much in the small child as in the mother. On the other hand, I speculated that the attacked dream reflected anxiety over castration or injury to the self, and the developmental period in which these regulators had been taken over from the mother and were internalized within the small child. The present paper carries forward these theoretical speculations, but with important modifications. For the sake of clarity the modified theory will be presented in advance of the clinical material, although in fact they were arrived at inductively after study of the data.

In accounting for the basic difference between the falling and the attacked group—namely that the internalizations appear, *for better or worse*, to be more strongly developed in the latter group—I have been particularly influenced by the writings of Anna Freud. She has called attention to the importance of distinguishing between anxiety over loss of *a* love object and anxiety over loss of *the* object's love (7). The modification in my theoretical speculations is essentially that the falling dream reflects anxiety over loss of *a* love object, whereas the attack dream reflects anxiety over loss of *the* love object.

Anna Freud's views may be summarized as follows. Up to the age of about five months, the infant regards the mother as a need-satisfying object; the mother can be replaced with or exchanged for another need-satisfying object without distress to the infant so long as need-satisfaction is maintained. This early stage of object interchangeability, of a need for *a* mother, is followed by a much longer stage of object constancy, of a need for *the* mother. Thus, after the age of five months the need-satisfaction can be altered so long as the objects remain the same. Separation from *the* object causes much distress, evidences of this being the infantile stranger anxiety and anaclitic depression. However, owing to the immaturity of the ego, primary need-satisfaction remains such a strong force that attachment to *the* love object who is absent (and thus not satisfying) cannot be maintained over long periods of time. As the child matures, he is able, according to Anna Freud, to maintain cathexis of absent love objects for longer intervals.

What, apart from constitutional factors, facilitates the infant's transition from the first to the second state is, according to Spitz (17), Benedek (2), and others, the constancy, the predictable need-satisfying quality of the mother figure. The dynamic underlying this constancy is the symbiotic involvement or identification of mother with child. To be wholesome, this symbiotic involvement should decrease in intensity in order that the child can pursue his own later autonomous goals without conflict.

In the earlier object-interchangeability phase, the ego's way of mastering anxiety would be to find another need-satisfying object. Since object constancy is not fully developed, little psychic work is entailed in withdrawing cathexis from one object and investing it in another. Since the id never really had the object, the ego is not required to retain or preserve the object by identification with it. Nor would the under-involved mother tend to oppose strenuously the child's search for other need-satisfying objects. The child is thus in *open* system where he can move to seek a new object rather than curb or inhibit the impulse which is being frustrated.

In the later object-constancy phase, however, the ego's more complicated task is to master anxiety by establishing some reunion or reconciliation with the same familiar love object. The solution by way of the general non-maternal environment is curtailed for several reasons. First, the child is concerned about the love issuing from one specific external object. Second, the over-involved mother may not approve of the disloyal and reproachful separation entailed in the child's seeking another object. Third, in order to retain the inevitably frustrating specific object, the ego has had to identify with it, and now has to contend with the demands and prohibitions of the ambivalent, internalized object. The child then is confined to a *closed* system where he must use countercathexis to tame his impulses—in particular to tame any rage which might destroy *the* specific love object or its internal representations.

It is this theoretical framework into which I

believe the forthcoming observations on falling and attacked dream predominance can be most appropriately placed. Thus, the falling dream can be thought of as a reflection of the open system, object-interchangeability phase, and the attacked dream as a reflection of the closed system, object-constancy phase.

The more classical interrelationship between the attacked dream and castration anxiety is omitted in this account. Although this paper will not deal with the subject, it should be pointed out that there are several theoretical considerations which suggest that the attacked dream may reflect object constancy as well as castration anxiety. Freud stated that object-loss and castration anxiety may be basically equated inasmuch as anxiety over loss of the penis could be traced to anxiety over loss of the breast (10). Upon disappointment with *the* specific love object (breast or mother), the object cathexis returns to be invested, as Hartmann points out (13), on the self. The self, then, becomes *the* love object (secondary narcissism) and can fear such injuries to the self as being devoured, robbed of bodily contents, or genitally castrated. It is in this way that I conceive of the attacked dream arising out of the object constancy phase and later being reflective of castration anxiety.

It would be impossible, owing to limitations of space, to present all the clinical material and other data which led me inductively to this theoretical structure. I must confine myself, then, to indicating—sometimes sketchily—the main supportive evidence.

II. Maternal Involvement

It has been suggested that the transition of the infant from the object-interchangeability phase to the object-constancy phase is due to the constancy of the mother, which, in turn, is due to her involvement with the infant. Involvement—a non-technical term—will be defined here as a situation in which the mother, positively or negatively or both, has identified herself in part with the infant. The essential feature is that there is an emotional closeness between mother and child, whatever the positive or negative repercussions may be. It has been further suggested that the attacked dream reflects this original mother-child involvement, whereas the falling dream reflects a maternal under-involvement.

The evidence I wish to present is drawn from several sources—the first being the patients. The mothers of the attack dream patients were much more frequently involved with their children than were the mothers of the falling dream patients. A characteristic situation was one in which these mothers would seek narcissistic and companionate gratifications from their children because of an unsatisfactory marriage. Disappointed in their husbands, they would cause the children to feel guilty if the latter did not gratify them. The mothers, for the most part, were ' home bodies ' with few outlets for gratifications other than their children.

The falling-dream patients did not appear characteristically to have that type of involvement with their mothers. If the original symbiosis, to be wholesome, should contain some elements of involvement, these patients seemed to have had less than the wholesome amount. One mother was a promiscuous alcoholic; two mothers were dynamic business women who exercised considerable competence and success in running their businesses; one mother was very ineffectual, but was completely wrapped up in her husband, and neglected her daughter because her husband needed her; one mother, although she had been a capable housewife and mother for twelve years, immediately went to college on her youngest son's graduation from high school and eventually got a medical degree. In milder forms the mothers were described as quite reliable and dependable concerning physical care of the children, but not especially interested in the children as persons. The variety of external pictures has one common denominator—that the mothers were not ordinarily absorbed in motherhood and did not even use it as a vehicle for working out their neurotic problems.

Another source of evidence, from an area requiring much further study, is the nature of the transference situation when the attack and falling dreams occur during treatment. Two examples are offered. In the first of these a patient reacts to a decreased distance between the therapist and patient; in the second to an increased distance. A young man who had been subjected to an intrusive, over-involved mother reported a dream in the 30th hour, or shortly after I had *returned* from a week's vacation. In this dream a black shape was about to attack him. During the hour he disclosed that he had felt quite comfortable during my vacation, but that the prospect of seeing me again made him feel uneasy, as though he were being surrounded. Apart from the interpretation of the black shape as being his projected rage, the attacked dream

occurred when the patient reacted to the treatment situation as one of intrusive over-involvement.

The other example concerns a middle-aged woman whose mother had played the role of an invalid, always ' on the point of dying ', and had delegated the care of the patient to maids. After a year of psycho-analytic psychotherapy she began to defend against the emergence of forbidden impulses by talking of stopping treatment. Because of a number of external reasons, I went along with her conscious thoughts and set a termination date. She then reported a dream: ' I was on the roof of a building. It was not far from the ground, but I was afraid I would hurt myself if I jumped, so I was waiting for a ladder.' The prospect of termination appeared to represent an under-involvement on my part, and stimulated a separation anxiety reflected in a variant of the falling dream.

In the literature there are two cases reported by Richard Sterba (18) which are quite similar to the young man's dream of the black shape. Sterba's theoretical explanation derives from a concept of Anna Freud's, namely, that ' in certain patients any approach on the part of the surrounding person is experienced as a claim or a hostile attack ' leading to subjugation. In Sterba's paper are described two cases of young women with over-involved mothers. In one case there was an early repetitive nightmare of being tickled to the point of paralysis by a big woman—in short, an attacked dream.

Other evidence of a statistical nature appears to support this speculation that the attacked dream is associated with proximity of the mother, whereas the falling dream is associated with separation from her. In 3,000 military selectees, a rough sample of the normal male population, those with predominantly falling dreams had a much higher percentage of homes broken before the age of six by the death of the mother than had those with predominantly attacked dreams. In 730 male military neuropsychiatric patients, loss of the mother as well as loss of the father before the age of six had occurred more frequently in falling-dream patients. These findings suggest that the falling dream is associated with a comparative lack of mother-child symbiosis or involvement—a comparative lack of stable external structure which can be internalized.

The last piece of suggestive evidence comes from the study of 54 so-called normal children and their mothers. The healthy supportive aspects of maternal involvement reflected by the attacked dream may be indicated by the finding that 75 per cent of the children had an attacked-dream predominance and only 12 per cent a falling-dream predominance. However, the unhealthy constrictive effects of maternal involvement, the effects of a pathological object-constancy phase in which there is no escape from the mother, could be seen in a small group of 11 children. For these children not only was the attacked dream predominant, but only two of them admitted ever having had a falling dream (39 of the remaining 43 children admitted having had the falling dream). The mothers of this group were especially prone to control the child by martyrdom (to have been injured by the birth of the child was a frequent claim), looked to the child for love and sympathy, and could not tolerate its aggressiveness. The children themselves were constricted in affect, showed little sex curiosity, and did not ' go easily to strangers '. They could not, it would seem, safely vent their anger or leave the mother—either solution being construed by the mother as an injury to her and an occasion for the child to feel guilty. The accumulation of repressed rage would then be projected as seen in the attacked dream.

III. Object Interchangeability and Constancy

It has been suggested that maternal under-involvement induces a continuation of the early need-satisfaction phase in which objects may be interchanged so long as needs are satisfied; and that maternal involvement or over-involvement induces a new phase in which identification with the mother is taking place and maintenance of the constant object may be more important than satisfaction of needs. Furthermore, it was suggested that the falling-dream predominance reflects object interchangeability, whereas the attacked dream prominence reflects object constancy.

For several reasons, this section is more complex than the previous one. In the preceding sections all that was required was to show a relationship between one causal factor—the kind of maternal involvement—and one repercussive phenomenon—the kind of typical anxiety dream. In this section, however, we might be expected to relate all the various complexities of early ego and superego development to the kind of anxiety dream. Even the phrase ' nature of child's relationship to objects ' is not delimiting enough, inasmuch as ' objects ' may refer to the external object, the internalized

object-cathected symptoms, or the self as an object. Because of this complexity and the limitation of space, the few observations and comments I shall offer run the risk of seeming oversimplified.

A convenient place to begin is a consideration of reactions to a separation. For it is under the stress of separation that the characteristics of object interchangeability or of object constancy will be more prominently displayed. The case of the hospitalized two-year-old reported by Bowlby *et al.* (4) illustrates this point. On separation from the mother, the little girl handles her object needs in several ways. Two of these are pertinent here: (i) displacement onto other objects such as a steam-roller and a little boy; (ii) a projective identification of her ' abandoned' self onto another forlorn little girl, after which she assumes the maternal role (via introjective identification) and comforts the other little girl. The authors suspected that, owing to the closeness of the previous mother-child relationship, i.e., the previous involvement, the denial of the need for the mother would not proceed too strongly; that the solution would take an internalized form with overstrengthening of the superego.

The two adaptive pathways open to the little girl are, I believe, the two pathways differentiating the ' falling ' and ' attacked ' groups. Displacement onto other objects and denial of need for the mother are characteristic of the object-interchangeability of the ' falling ' group. On the other hand, projective and introjective identification which preserve the mother are characteristic of the object-constancy-' attacked ' group.

Evidence supportive of this interrelationship may be seen in the normal study. Sustained maternal warm involvement, as estimated by the social worker, was much more frequent in the mothers with ' attacked ' dreams predominant than in those with ' falling' dreams predominant. Like the hospitalized two-year-old, the ' attacked ' mother seems to satisfy her own need to be mothered by projecting herself onto the child, and then, after identifying herself with her own mother, loves the child as she herself wishes to be loved. (These mothers frequently reported that the child reminded them of themselves.)

The ' falling ' and ' attacked ' patients showed characteristic differences upon separation. Generally speaking, the ' falling ' patients, in keeping with their need-satisfaction orientation, had simpler, more direct reactions comparatively devoid of intrapsychic elaboration, and were desirous of substitute satisfactions. One female patient, on my announcing that I would have to miss the next treatment hour, asked, at the end of the hour, for some pills. A male patient whose request for reducing the frequency of visits had been granted, mentioned in the next hour that for some reason his stomach had begun to feel ' nervous '; otherwise during the hour he mentioned no troublesome thoughts or feelings. More tempestuous and direct was another female patient who came in for her hour openly furious over the fact that I had acceded to her request to take a short trip with her husband, and had thus abandoned her. On another occasion, after I had informed her of my taking a trip, she invited my wife and myself to a party at her home.

In contrast, the ' attacked ' patients more often had subtle complex reactions in which not the need-satisfaction, but rather the defence against the need and against the frustration rage, was predominant.

Illustrative of this in a male ' attacked ' patient with depressive and homosexual symptoms are the following excerpts from the material of two successive hours (35 and 36) after I had announced an interruption in my schedule in the 34th hour. Hour 35: ' Too much cigarette smoke in here . . . Feel an internal irritation . . . feel like I'm standing by waiting to see what is going to attach itself—thinking of candied violets—once I ate them and they tasted like perfume.' Hour 36: ' Feel uncomfortable about having been a donor for artificial insemination two weeks ago—I would like to be the real father, not just by proxy. I think of having a son, but probably would bind him too closely to me.'

The sequence of material may be interpreted: (i) Rage over the separation; (ii) as defence against the rage destroying the specific needed object he resorts to oral incorporation; (iii) having incorporated or identified with the mother, he loves his projected self in his off-spring.

Apart from separation reaction, other aspects of interchangeability and constancy may be seen in the treatment situation. For example, the constancy of the patient in relation to treatment was much more evident in the ' attacked ' group than in the ' falling ' group. Of the former group 22 patients (34 per cent) as compared with 3 (19 per cent) of the latter group continued treatment past 200 hours with a frequency of at least three times a week.

A similar difference may be seen in the area of symptomatology. The 'falling' and 'attacked' groups differed not so much in the actual symptoms occasioning referral as in the constancy of the presenting symptoms. Whereas the 'attacked' group might, for the most part, present a chronic symptom such as homosexuality or depression for a number of years in treatment, the 'falling' group more often alternated symptoms or fluctuated more quickly between having symptoms and being asymptomatic. An example of this was a falling-dream woman. In the achievement area she had fluctuated between being valedictorian of her high school class and dropping out of college after a half year. In the somatic area, before and during treatment she fluctuated between bulimia, causing a weight of 190 lb., and a food avoidance which brought her weight down to 95 lb. within a year. For periods of some weeks in the treatment she would feel perfectly well and would wish to stop treatment.

More subtly indicative of interchangeability and constancy was the kind of transference reaction manifested respectively by the 'falling' and 'attacked' groups. The 'falling' group in general displayed less intense transference reactions to me than did the 'attacked' group. They seemed to require the presence of any object who represented strength and protectiveness, whereas the 'attack' group seemed to require a more particular somebody, a more well-defined object who understood them as individuals, who was *en rapport* with their internalizations, and who corresponded with their projected idealizations.

Not only with me, but also in their social relations and friendships with others, did these differences show. The 'falling' group tended to have a low intensity, uniform 'friendly' cathexis to many people, and were more able in a 'The king is dead, long live the king' fashion to forget about old friends and to make new ones. The 'attacked' group was less able to change or reduce the libidinal cathexis. They had a few close friends from whom they required an intimate one-to-one rapport; they clung to their memories and were mindful of the dead king rather than of the new.

The object-interchangeability implied in the *one-to-many* rapport and the constancy implied in the *one-to-one* rapport were also seen in the opening dreams of treatment. 'Falling' group opening dreams were more often of a triangular nature (Example: 'I was talking to my girl-friend in the office when a man came in and told me to get out,'), whereas the 'attacked' group's opening dreams were more often of a one-to-one nature (Example: 'Having intercourse with a woman who had a penis.'). The triangularity is, I believe, a step in the direction of the open-system object-interchangeable adaptation. Furthermore, the oedipal undertones of the triangularity suggest that the 'falling' group—who did not experience much symbiosis in the orally dependent mother-child relationship—tend to utilize genitality for symbiotic purposes. On the other hand, the one-to-oneness seen in the opening dreams of the 'attacked' group is more clearly an indication of object-constancy, of a concentration of cathexis on the specific object. It is of interest in this connexion that Martin Buber traces the origin of his one-to-one 'I and Thou' religious philosophy to an attacked dream he had in childhood in which an animal was biting off a piece of his flesh (5).

In the psycho-analytic literature most case reports bear a strong resemblance to the attacked-dream patients with their characteristics of object-constancy and mechanisms of identification and projection. Cases resembling the falling-dream patients are rarely reported. A notable exception, however, is the patient described by Anna Freud in a discussion of a panel on the widening scope of indications for psycho-analysis (8). Owing to early and drastic interruption of the mother-child relationship, the girl had no stable object ties. Adults were important for her as sources of pleasure, but not love objects in the object-libidinal sense of the word. 'In the analysis of such patients we find there is no hidden fund of archaic object love or hate on which the transference can draw.' Cathexis is easily withdrawn from the therapist, continually interrupting the formation of a transference neurosis. 'On the other hand, the intimacy of the analytic setting is well suited to reproduce—or where necessary to produce for the first time—the intimacy of the mother-child relationship.'

The parallels between the above case and my 'falling' patients are, I believe, quite striking. The early interruption of the mother-child relationship, the 'thinness' of the internalizations, the orientation towards need-satisfaction, the object-interchangeability in which cathexis is easily withdrawn and reattached, and the lack of ability to concentrate the libido fully on an object in a one-to-one relationship—these are the striking parallels. Although Anna

Freud offers a more extreme set of etiological circumstances than I, the quality and effect of these circumstances are similar. Thus the under-involvement of the mother is but a milder form of actual separation from her.

Discussion

The aim of the foregoing presentation has been primarily to arrive at a general meaning of the 'falling' and 'attacked' dreams. To this end, existing theoretical concepts have been utilized to provide a framework for the empirical data. Since the data have been collected from adults and children no younger than 8, my reflections on what happens during the first year of life must be considered speculative. Further data issuing from such investigators as Bowlby on early human behaviour and Harlow on early primate behaviour may support the conceptualizations here offered or may necessitate some revision of them.

Although there is an analytic typology implicit in much of what has been presented, it is not recommended that this be applied rigidly. One reason is that the usual occurrence of both dreams in the same person (despite predominance of one dream) militates against establishing a sharp, mutually exclusive delineation. Another reason is that more study is necessary to substantiate the correlations—especially a systematic study of the falling and attacked dreams as they occur during the course of treatment.

Concerning a possible typology, however, a few remarks are in order. Since both kinds of dream and their predominances are reported by persons in normal and abnormal samples, there is little evidence that the predominance of the dream type has much to do with whether the person is psychologically healthy or sick. The position which I believe it is safer to take is that the two groups represent two paths of a divergent characterological evolution, each with its particular strengths and limitations.

The matter of comparative psychological health may rest on the question how healthy it is for the ego to have been modified. There is no doubt but that the attacked group has undergone, by virtue of its tenacious identifications and internalizations, much more ego-modification than has the falling group. Yet there is a division of opinion in psycho-analytic literature as to the desirability of ego-modification. In the writings of Eissler (6) and Alexander (1) there is a definite suggestion that the least modified ego is the healthiest. David Beres (3) states that considerable growth in ego function of mother-deprived children can take place in subsequent years.

On the other hand, the ego modifications attendant on the oedipal complex resolution are considered to be a sign of healthy maturation. Rappaport ascribed ego strength to the person who can tame and modulate his affects by means of counter-cathectic forces (15). Furthermore, we have been accustomed to thinking that a person such as the 'attacked' person who can be analysed by virtue of his having internalized objects capable of transference projection is psychosexually more mature than is the person—like the 'falling' patient—who may first have to acquire strong internalized objects before he can transfer them in analysis.

In view of the foregoing, the safer position regarding the psychic health of the falling and attacked groups would seem to be the middle one. Expressed in terms of intrapsychic structure, it is that the strongest ego is not one which has been unmodified, nor one which has been excessively modified, but rather one that has been optimally modified. The unmodified portion of the ego, that portion which is an ally of the id, facilitates need-satisfaction; the modified portion of the ego, that portion which inhibits the id, facilitates internal instinctual regulation.

Expressed in terms of object relations it is that the combined capacity for object-interchangeability *and* object-constancy is more adaptive than the capacity for either alone. In the maturation from the need-satisfying-object-interchangeable phase to the object-constancy phase, the former should, it seems, gradually yield dominance to the latter, but should not be repressed and non-utilizable. By possessing both capacities, the person is able to change from a frustrating anachronistic situation to a gratifying new situation which he can cathect more permanently.

It is in these basic, comprehensive terms that I believe a *general* meaning of the falling and attacked dreams may be found.[1] Less basic terms may not do justice to the fact that anxiety is the affect *par excellence* from which character structure arises, and to the fact that these dreams are the two most common typical anxiety dreams.

[1] I have expressed similar views in connexion with a study of normality (12).

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THE PSYCHO-ANALYTIC TREATMENT OF A CASE OF CHRONIC REGIONAL ILEITIS[1]

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The psycho-analytic treatment of psychosomatic disorders is still a controversial issue among psycho-analysts. There seems to be a reluctance to use psycho-analytic techniques with such patients. Definite indications of which cases are treatable are not as yet established. This case history is presented in order to demonstrate the applicability and usefulness of the analytic technique as a therapeutic tool as well as a means of increasing our knowledge about the psychodynamics operating in ileitis. I selected the material for this presentation from the analysis which extended over three years with the intention of letting the patient speak rather than the analyst. Therefore only few interpretations of defences, resistance, dreams, and transference are incorporated into the case history, although such interpretations were given from the very start of the analysis.

The patient was 44 years old at the time he started analysis. He was suffering from chronic ileitis of long standing. The presenting symptoms were abdominal cramps and diarrhoea. He had developed these symptoms when he started college. He had an acute exacerbation at the age of 31 when he was considering marriage. He was then in a bad state, and shortly after his marriage he had to undergo surgery. A transverse ileonostomy was performed, but the symptoms returned after a short time and he had no relief from the operation or from medical treatment. Although he knew of and had read about psycho-analysis and accepted that emotional tension could cause illness, he did not think that he could be helped by it. He had been told that there was no cure for his illness and all available medical treatment had failed. He had accepted referral to me upon the urging of a friend and since nothing so far had helped he was willing to try.

A brief summary of the Rorschach he took prior to starting analysis follows:

(i) He presents a picture that looks on the surface obsessive, compulsive, but his basic personality structure is at least schizoid.
(ii) There is evidence of a thinking disorder.
(iii) His defences seem to consist of intellectualization and withdrawal.
(iv) It is the opinion of the examiner that there will be great difficulty in analytic treatment. However, he will most probably respond well to reassuring and supportive treatment, as it seems that he is at present in a great anxiety and almost panicky state.

At first the analysis dealt with his inability to express himself and to show feeling. At times he would feel constricted in the throat and his voice would become weak. He said that he had practised not expressing or showing any feelings for such a long time that now he actually had none. He remembered that he was always that way, and even as a child he never showed excitement. He remembered an incident when he was 9 years old. He was in the movies with other children. All the others were excited about the picture, and when he felt himself gripped by the excitement, he felt his pulse to see whether it was beating faster. In this way he had learned very early to control and stop his excitement. He was a very good child. He always accepted authority and never rebelled.

He could do only a minimum amount of work in his office and at home he would require a lot of rest and quiet. He could not help his wife in the house or with the children. She could not leave him with the children when he was at home because he would get cramps and diarrhoea. He left all decisions and arrangements to his wife. He would not answer the phone at home to avoid embarrassment, since he could not make any arrangements or impromptu decisions. He said that he felt like a rabbit to a lion in his relationship to his wife. He was given the interpretation that feeling so helpless he had to resort to magical ways of coping with powerful people; cramps and diarrhoea. He very often associated in the form of visual imagery which he

[1] Paper read at the Annual Meeting of the American Psychoanalytic Association in San Francisco, 9 May, 1958.

called ' mental pictures ', and to this interpretation he associated a picture: he saw his mother talking to someone and himself as a little boy tugging at her skirt. If she didn't come right away when he called her, he took it very badly.

He had always related his bellyaches to food. On several occasions he had the experience that certain foods which previously had caused severe cramps he could now eat without any untoward reaction. He himself began to tie up the cramps and diarrhoea with his reactions to people and situations. He reported the following dream: He saw someone commit murder. The murderer saw him and so he started to run. Some associations: Some people call diarrhoea ' the runs ', ' running to the bathroom '. In a symbolic way, this is running away, he said. Again he had visual imagery as associations: scenes from early childhood, mischievous children running away. One of the children snatching something from a fruit store; a little girl permitting him to inspect her.

He often had cramps and diarrhoea during the night. One night he vomited but had no diarrhoea. He said that he had got rid of the supper during the night by vomiting. He felt that he had been gluttonous that evening ' the way I attacked my supper'. He had very severe cramps and sat up in bed until four in the morning. He thought of labour pain. That's how it must feel. While relating this he thought of a ' Spartan ' story: ' A boy had a fox hidden under his clothes and would not admit that he had the fox hidden. The fox tore his insides out.' The virtue was not to be caught. ' This is an odd association to come to my mind ', he said. 'What's so Spartan about me?' He remembered that he used to vomit as a child, especially when fed soft-boiled eggs. The sight of the soft bluish white made him vomit. When he hears his little daughter gag, it reminds him of himself as a child. The white of the egg reminded him of the colour of spermatic fluid. Again he had a vision: He saw himself hiding away in the bathroom when he first started to masturbate as an adolescent. In another mental picture he saw himself standing in the corner in the school with chewing gum on his forehead.

In one of his sessions he complained that his lunch didn't seem to be going down. When asked what he thought it was that wouldn't go down, his answer was ' pellets of hard faeces '. This is a strange association, he said, and he thought of his little daughter when she is constipated. His wife then uses the phrase, ' Little hard balls, like rocks.' He thought of an incident where he dipped his hands in the lavatory pan to pull out some spoons the child had thrown in. He also thought of the time he retrieved a penny from the stools of his little son, which the boy had swallowed. He was able to do this, he said, by holding his nose so as not to ' smell '. ' It is hard to say such things. It's like being nude when everyone is dressed ', he remarked.

He remembered a fragment of a dream from which he awakened with severe cramps. He had swallowed something indigestible: a large marble. When he awoke, he had felt a lump in his belly, and now that he spoke about it, he felt a lump in his throat. I just swallowed it down, he said. What he swallowed was much larger than a marble, and it wasn't really a marble, he said. His fear was that it would have to be cut out from his intestines. This type of dream was a recurrent one which he had for many years and from which he would awaken in great anxiety.

He used to be in the habit of chewing toothpicks. When in college, he thought that swallowing these chewed-up pieces of toothpicks had caused his ileitis. He would talk about this to some of his friends and instructors, who laughed at him and reassured him that this was not possible.

He had a great fear of vomiting and nausea. He also had a fear of choking and passing out. When he would get the abdominal cramps, he would shiver and his muscles would contract. He remembered that, as a child, when he had to get up in class his knees would tremble so that he had to steady them with his hands.

In discussing the feeling of a lump in his throat, he said that he had experienced this feeling for the first time at his mother's funeral when he was 21. At first he had said ' When I was 17½,' and then corrected himself that that was the time he had left for college. This slip revealed that leaving mother and mother dying were unconsciously equated, and that the onset of his symptoms coincided with his leaving his mother. At the funeral he had a frozen face. There were no tears. He had the same feeling at the funeral of his niece, whom he liked, and at his father's funeral. The only place where he experienced such feeling now was in my office. It felt as if something got stuck in his throat and if it came down it would do him harm and cause cramps.

He began to complain about experiencing feelings he did not have before. The other day somebody told him something flattering. He felt elated. When something unpleasant is told to him he now feels depressed out of all proportion. Before it didn't matter what anyone said. But then he questioned himself. Didn't it really matter? ' It hit my guts ', he said. Which is better? he asked himself. ' Now I feel like a screwball. It is not normal to oscillate like that.' His ideal was the Englishman with the poker face, and he had always thought himself too big for such petty feelings. To discover that he was jealous and envious was more painful, he said, than the bellyaches. He could never say that he cared for someone, really liked someone, and during one session when he spoke of his youngest brother and said that he was fond of him, he stopped and then asked, ' Isn't it odd to go through a lifetime and never have said such a sentence. It makes me feel great to say it.' His art teacher would tell him that his paintings lacked colour. He would choose only pale colours, mostly grey. He could never use

strong, intense colours. Everything to him had been grey. Now it felt as if the light were suddenly brighter.

There was marked improvement in his condition. He had only very occasional diarrhoea and cramps, and when he started to develop pain, he could, as he put it, ' hold it off ' and forestall a severe attack. He now began to complain more often about feelings of depression or ' throaty feelings ' as he called them. He felt very unsure of himself and his ability to handle emotion. The other day, when his little daughter was crying and was told not to cry, he could see it go into her throat and form a lump there. ' I hope she doesn't develop the lump in the throat as I did. If we could just let her cry it out ', he said. His fear of being at the mercy of his feelings was expressed in some of his mental pictures: A little object tossed around on the ocean; A pool of water and somebody prompting him to dive in. ' I can't swim ', he said.

At this point some remarks concerning the technique of treating a psychosomatic patient psychoanalytically seem to be indicated. The phase of analysis when the immediate release of impulses via the somatic symptoms is interfered with through analytic interpretation, but the unconscious fantasies and the infantile structure of the patient's personality have not yet been fully analysed and changed, is a difficult one. Yet this is an unavoidable phase in the treatment, because the patient has to learn to accept and to tolerate consciously painful emotions and feelings of depression. For the first time in his life such a patient is faced with the possibility of having to give up his fantasy of omnipotent control over the needed object (which he had acted out) in the somatic symptoms, and to accept a more mature object—relationship. It is during this phase that mistakes made earlier in the treatment will be of the most serious consequence and not only preclude further progress but may precipitate an acute exacerbation or even a psychotic break.

I have in mind particularly such techniques as the anaclitic type of treatment which encourage regression and support the patient's belief in omnipotence and his feeling of inability to handle his emotions and to accept responsibility for his behaviour, emotional as well as somatic (1). The so-called ' supportive treatment ', in my opinion, is not supporting the patient in his meagre attempts to get well, but is rather supporting him in his strong wish to remain sick. A dream of my patient is significant in this respect. In the dream he was arguing with somebody about the price. The day before the dream we had discussed that he was paying a high price for what he was getting by being sick and denying his true feelings to himself. The patient had said, ' Illness is the key to the heart '.

I have found that there is no better way of safeguarding the patient during this period of analysis than through his relationship with his analyst. In the transference relationship, the patient partakes of the strength of the analyst. The analyst, by not succumbing to the patient's fear of the nature and urgency of his impulses, conveys to the patient (as the parents should have done to the child during the original phases of instinctual development) the feeling that he may experience such impulses and yet be able to delay and if necessary to forego their gratification.

My patient now, instead of analysing his dependence, would have liked to shift it to the analyst. To my interpretation of this, he reacted by seeing a picture: Himself as a little boy and his mother taking him by the hand. That is what he would have wanted the analyst to do. That is how he thought he could face the world. He complained about the analytic relationship. ' It's an odd relationship. When I am here, I feel fine. If I could only take more with me.' He reflected that it would be preferable if he could do his analysis from books. He could always have books with him. He was afraid to become involved in the analysis with his feelings.

He was now in the second year of the analysis. He was bothered by his feelings and he also complained of occasional dizzy spells. ' If I have a cramp or diarrhoea, I feel mentally at ease,' he said. ' Then I am not depressed and give my attention to my symptoms.' Now he would find himself, instead of having cramps, in a daze, as if his mind were away somewhere. The other day somebody remarked to him: ' You look as if you could bite somebody's head off.' This never happened to him before. He had his facial expressions so well under control.

The analysis now took on a different flavour. He began to speak about matters which before he had guarded carefully. He often would say, ' I have a secret. It you only knew the real me.' He told me that he had a rectal discharge which was very copious at times and which stained his underwear. Although he used lots of toilet paper, his underwear was always soiled. He felt guilty about this and, with a grin on his face, he would tell me that he was trying to hide his dirty underwear from his wife like a child would hide dirty pants from his mother. Because of the smell from the liquid brown discharge, he would take daily showers. ' It's like a frothing of the mouth, only it comes out at the other end.' He had been considered a smart child because he trained very early, he told me. One could tell by looking at his underwear, he said, what sort of a day he had been through. He thought of one physician who specialized in rectal work. This physician lets his patients wear menstrual pads. He said that he could tell by the shape of the faeces whether his colon was relaxed or tight. Even by passing wind he could tell by the sound whether it was relaxed or tight. He told me that he could well differentiate between the spasm and the contraction for bowel movements, but he would try to use the spasm for bowel movements and would be very unhappy if he did not succeed, feeling that he would explode.

He began to tell me about his interest in sex. He remembered that, as a child, he would bring home a cocoon in winter and then keep it near the radiator until the butterfly came out. He would germinate peas and beans and add fertilizer which smelt all over the house. His mother didn't want him to do this, but he has continued it to this day. He is still very much interested in planting and he keeps plants and a fish tank in his house. He had a very vivid memory of something that occurred when he was three or four years old: ' There was something in a dish which was covered. Everybody was very secretive about it.' When he thought of it later, he thought it must have been the placenta. He is one of six siblings, next to the youngest brother, who is 2½ years younger than the patient. He thought of himself as looking like a woman; fat around the chest and hips. Maybe this is due to not having enough male hormones, he said. While he was speaking about this, he experienced a cramp going down to his genitals. He now told me how he thought his ileitis started. The first symptoms were cramps going down to his legs and his genitals. Preceding and during the ileitis attack, there was sensitivity in his testicles to pressure. Also, when he feels tense, his sphincter tightens so that he can't get his finger in. After a good night's sleep or in the shower, the sphincter relaxes. Under a hot shower he would sometimes masturbate. He would not let himself have an ejaculation, but would try to separate orgasm and erection in time and let it drop out, not squirt out.[2] He had not masturbated much in recent years because he did not have the strength, he said.

His ideas of having harmed himself inside by swallowing something came up again, now in connexion with infantile sexual fantasies of oral impregnation in which the sperm was represented by worms and insects. For instance, in one dream he was served a dish of Swiss cheese, the holes were filled with insects; in another dream he was feeding worms to his wife. In this connexion, it may be of interest that in his Rorschach a preoccupation with insects had been noted. On the conscious level he added to the accusation of having harmed himself by swallowing chewed-up toothpicks another one which he thought caused his ileitis. He related that he had also been in the habit of eating Indian nuts. He would not bother to shell the nuts, but cracked them with his teeth and swallowed them with the shells. It was his hoggishness that made him sick, he said.

Homosexual fantasies related to the ileitis began to emerge in the analysis. He had a series of dreams in which he was attacked in his belly. In one dream, he was a prisoner and the policeman hit him in the stomach. He doubled up in the dream. That night he had seen a prize fight on TV. He could not see anyone getting hit in the belly, he said. It did something to him. In another dream, his father made advances towards him as if to hit him in the belly. His father appeared to be crazy in the dream (his father had a senile psychosis before he died). His father had never struck him. When he was twelve years old, a friend whom he had been teasing hit him in the belly. In later years he tied this incident up with his illness, thinking the boy might have injured him.

He has a fear of bending down; it would bring on the cramps and diarrhoea. He remembered an incident when he bent over to tie his shoelace and blacked out. This was shortly after his mother's death.

He thought of the circumstances under which he got married. At the time he met his wife and had an acute exacerbation of the ileitis, he thought that perhaps it was a good idea to have someone around. He had known one girl before he met his wife and had made it clear then that he had no intention of getting married. This girl had a nervous breakdown. He can't understand to this day how anyone should have a nervous breakdown over him. Much later in the analysis he told me that when he got married he didn't think that he would live. He thought that he would soon die, he was so sick. His mother died after a gall bladder operation. She had suffered from it for a long time. His father was opposed to surgery. The patient thought that he, too, would not survive the operation.

The analysis was now nearing the end of the second year. There were marked changes in his relationship with his wife and his children. He could now not only discuss matters with his wife but even argue with her and win his points. (At this point his wife thought that he had improved enough and didn't need any more analysis.) He actually became interested in his children with whom before then he had competed as a rival sibling. He had considered them his wife's children and a nuisance. He had no cramps or diarrhoea, although he now exposed himself to situations which he had previously avoided.

He now developed a new symptom: spasms of the eyes, particularly the right eye. He complained that he could not focus sharply, that it occurred in tense situations, and he compared the tightening of his eye to the tightening of his anal sphincter when he felt tense. He said that it occurred when he was trying to peer intently at something. It was found that this was not an entirely new symptom and that he had had spasms of the eye with blurring as a student in college when he worked in a laboratory. He had then attributed it to eyestrain. This symptom occurred at a time when the analysis dealt with highly charged scoptophilic material relating to the primal scene and birth of his brother. By this time he had gained sufficient insight into the dynamics of

[2] His need to divide these experiences is a further indication of his fear of being overwhelmed by strong emotions and a striking illustration of the mechanism described by Otto E. Sperling (11).

his ileitis to preclude the use of these symptoms. He worried that he would go blind and he seriously considered giving up his work completely. He had felt all along that, with his health improving, his wife had begun to make too many demands upon him. At this time, she wanted him to buy a home and to make considerable changes in their living conditions. He, on the other hand, did not want to assume more responsibility and would have preferred to speculate with his money, entertaining the fantasy that he would get rich overnight and would not have to work at all any more.

The analysis dealt with his resistance: his wish to give up his work, the analysis, and his disappointment in the analyst who he felt was depriving him of his ' excuses '. ' Maybe I don't want to get well. Maybe I want the *status quo*,' he said. After some of this was worked through, the patient brought material from his early childhood. In association to a lengthy dream in which he was in a place where he was not supposed to be and which also dealt with a camera, photography, and looking, he produced a series of memories from the time when he was three or four years old or probably even younger. He remembered a visit to the hospital when his cousin was ill. The patient wanted something this cousin had, maybe a toy, he said. He clearly remembered the hospital room and the layout. He couldn't quite understand how he could have been there since children were not permitted. He thought of his grandfather, who had a red beard, but whom the patient had never seen. Then he thought of his father's stained clothes. He couldn't understand this because his father was meticulously clean. Then he remembered an incident when he had watched his father doing something to a callus on his foot. He saw his father's foot up on the kitchen stool and himself watching. He saw the gaslight. There were no electric lights as yet. ' I can still smell the ether contained in the preparation which my father used ', he said. He must have been four years old or younger at that time. He then remembered another incident which impressed him very much. He must have been very young then, he said. It was a Friday night and the brandy was set on fire. He watched. Some brandy spread onto the table and burned. This took him back to another memory which he had mentioned before in his analysis and which he had intellectually and in retrospect related to the birth of his brother. He now saw the covered dish and how everything had been hush-hush, as if he were not supposed to know. ' I just felt a lump in my throat. I thought of little milk cans on a wagon. I never got one. ' I treat you both alike ', I hear my mother and father say. I never let him play with my group of friends and to this day I get a certain respect from him.' (This referred to his $2\frac{1}{2}$-year-younger brother.)

It was during this phase of the analysis that the following incident occurred: The patient saw the superintendent of the building in which he lived with a bandage over his eye. He inquired about it and the superintendent told him that he had got his eye sore from working in the sewer cleaning out the dirt. My patient was particularly impressed when the superintendent indignantly told him that there had been condoms swimming in the sewer. That night my patient had the following dream: He was in a dormitory or big bedroom. (The patient is one of six siblings.) There was a toilet next to each bed. He was wondering about privacy. He vaguely remembered two people in the dream. He thought they were his parents. He saw two condoms lying on the floor. There was no anxiety in the dream, he said. But he had to get up immediately after awakening from the dream and go to the toilet to urinate. He felt slightly dizzy when he got up as if there were something wrong with his eyes. On the way back from the bathroom he almost fell and hit his toe against the door. He became panicky in anticipation of the excruciating pain that he would now experience in his toe. He slumped on his bed, palpitating and trembling, and waited for the pain to come. Strangely enough the anticipated pain did not come. In association to this dream, early memories came up about his getting up at night to go to the bathroom and passing his parents' bedroom. He remembered an incident which struck him as very odd when he reported it. He thought of the time his friend got married and the patient and his younger brother went along on the friend's honeymoon. ' It was a sort of a one-room affair ', the patient said. They all shared a cabin in the mountains with hardly any partitioning.

After this material and the patient's reluctance to assume the responsibilities of an healthy adult were worked through in the analysis, his eye symptom cleared up and the patient bought the house. He had now been in analysis for two-and-a-half years. It was gratifying to see how this man, who before had been afraid of any activity, and had spent his free time resting or reading, was now working in his house and garden unafraid of bending and obviously deriving great pleasure from these activities.

It seemed that the patient at this point was reluctant to go further in the analysis of his unconscious homosexuality. He produced material which indicated that he knew what his real sickness was but that he wished to think that his analyst (mother-wife) did not know. In one dream a little old lady in an old-fashioned dress with puffed sleeves was examining a little infant boy who was full of bumps. There was a sick cat in the room. The patient said something. The old lady said she was a professor. In the patient's mind, cat was associated with homosexuality. He was the sick cat, he said. He had reported another dream shortly before in which two snarling cats were spitting at each other and he had then associated two men who had had a heated argument and whom he suspected of homosexuality. The old-fashioned dress reminded him of a dress his mother wore in an old photograph. His mother

really didn't know whether to treat him as a boy or as a little girl. When he thinks back, it strikes him that he really behaved more like a little girl.

The analysis was terminated at the end of three years by mutual agreement. The patient said, 'I know I need more analysis but I'll make it do.' Three years have passed since the termination. The patient has remained well and is enjoying his work and his life.

Summary and Conclusions

Among the various psychosomatic disorders which thus far have been investigated psychoanalytically, regional ileitis does not seem to be represented. At least I could find no reports on it in the psycho-analytic literature (12). My patient was a chronic case of regional ileitis of long standing with a history of frequent acute exacerbations and of unsuccessful surgical intervention (transverse ileonostomy) 13 years prior to the start of analysis.

The psychologist, on the basis of the psychological records, advised against psycho-analysis and suggested some form of supportive psychotherapy. The patient himself was reluctant and very sceptical about the value of psychoanalysis in his case. The situation did not seem very promising.

In treating patients with various psychosomatic diseases, in particular ulcerative and mucous colitis, who from the medical and psychiatric points of view had been regarded as poor risks, I had learned that the only approach which worked immediately and in the long run led to remarkable permanent improvement and in some cases to cure, was a psycho-analytic approach as I have described it (2, 3, 4, 5, 6, 7, 8, 9, 10).

The significance of the cramps and diarrhoea as this patient's form of somatic rebellion was pointed out at the beginning of the analysis and followed up shortly after with the interpretation of the unconscious significance of cramps and diarrhoea as a way of omnipotently controlling frustrating objects by squeezing them through his intestines and by devaluating them and getting rid of them as faeces. It was interpreted to him further that any situation which he felt he could not control in reality, provoked an unconscious feeling of helplessness with danger of loss of control over himself; that his struggle for control was then acted out somatically on the anal level at which sphincter, muscular, and emotional control are learned and acquired.

His youngest brother was born when he was $2\frac{1}{2}$ years old and at the height of the anal phase. There was only one way in which to compete successfully with the baby brother for his mother's favour. He had to repress his anal impulses and to be compliant and good at all times. He could never incur his mother's disapproval. Under the influence of strongly repressed homosexual wishes and on the basis of his anal fixation, a shift from genital to various forms of anal sexual activities seemed to have taken place in adolescence.

After these aspects of the patient's presenting symptoms, somatic as well as emotional ones, had been dealt with, the patient could bring into the analysis his infantile sexual fantasies, fears, and wishes associated with and gratified by his symptoms.

Although he had at first dated the onset of the ileitis symptoms to the time when he started college at $17\frac{1}{2}$, it was found that specific symptoms, namely, the cramps going down his legs and to his genital and the sensitivity of his testicles, preceded and persisted during his illness.

He developed abdominal cramps and diarrhoea on separation from his mother with intensification of these symptoms after her death when he was 21 years old. He had not been interested in girls and had not thought of getting married. When he met his wife he was 31 years old and suddenly confronted with having to make a decision to marry. He had an acute exacerbation, and it was then that the diagnosis of regional ileitis was established in the hospital and he was told that if his condition did not improve he would have to undergo surgery. In these circumstances, he decided to get married and shortly thereafter the transverse ileonostomy was performed. Although his wife was younger, he knew that he married her as a mother substitute and he established with her the relationship he had had with his mother. He was the good child who never rebelled, and she took care of him. As he put it, his illness was the key to her heart.

It might be of interest to compare the findings from the analysis of this patient with those from the analyses of patients suffering from ulcerative colitis. The outstanding symptom was his tendency to spasms, especially of the intestines. Although the diarrhoea was a prominent symptom, it did not have the character or intensity found in ulcerative colitis. There was no blood or pus in his stools and he had no anorexia, which is another very prominent symptom in ulcerative colitis.

His fantasies about the ingested harmful objects were more of a hypochondriacal nature. This was also apparent in his feelings about the operation. He thought that the surgeon had not cut out enough of the ileum. But what he really meant was that surgery had removed only part of the ileum and not the harmful object inside.

The ulcerative colitis patient has an intense urge to get rid of the oral sadistically incorporated object immediately, and this process takes place in the colon, which is the organ for elimination. I have found that the fixation point in ulcerative colitis, especially in the severe cases, is primarily to the oral sadistic level with underlying depression. In this case, the fixation was primarily to the anal and more specifically to the anal-retentive phase with underlying obsessional hypochondriacal and schizoid features. I am aware of the fact that no definite conclusions can be drawn from the analysis of one case, and I am offering these ideas as suggestions for further investigation.

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THE METAPSYCHOLOGY OF AUTOSCOPIC PHENOMENA

By

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An autoscopic phenomenon is the encountering of an image of oneself. The image may be an hallucination; it may be an illusion, as when one takes a mirror image to be a person; or it may be a vivid fantasy. Most autoscopic phenomena, as the term implies, are primarily visual, but often other sensory modalities participate: the image may speak, or it may touch the subject.

Autoscopic hallucinations occur in cases of brain damage, particularly when a portion of the lesion falls into the parieto-temporo-occipital area. They may form a part of a psychic seizure, or they may occur separately (1). They have been described in cases of structural and non-organic disease of different kinds, especially frequently with migraine and epilepsy (5, 16), but they have also been reported autobiographically by a number of normal, in fact distinguished individuals as well, for example, Archbishop Frederic (E. J. Lloyd) (5) and the physicist, Ernst Mach. Freud, too, has described his experience of an autoscopic illusion (2, p. 248).

The idea that an individual has a 'double' has been a fascinating one, and the 'double' is a favourite theme of writers who attempt to create weird and uncanny effects. Freud deals with the subject in his paper on 'The Uncanny'. He first briefly reviews Rank's observations and suggestions. Rank wrote that the concept of the double is an attempt to insure against the death of the individual, much as a multiplicity of limbs acts to deny castration. 'Doubling' is a manifestation of primary narcissism, though subsequently, in adult life, the double appears as a harbinger of death. Freud adds that not only may the image of the body, which resides in the ego, be split and reduplicated, but splitting of the ego may constitute a normal aspect of development, that is, creation of the superego by detachment of a part of self-observation and ego ideal. However the unsettling effect of the doubling phenomenon is probably to be ascribed to the fact that it is a repetition of a psychic event which occurred during the period of infantile narcissism.

A related phenomenon, illusory reduplication of paralyzed or lost body parts in cerebral disease, I attributed (8) to the effect of a rebirth tendency or instinct which comes into play when an individual living organism or group sustains a loss. I cited as an example the schizophrenic's tendency to repopulate a world which seems dead to him.

In this brief report I shall attempt to elucidate the metapsychology of autoscopic phenomena on the basis of some clinical experiences.

Case A: A 16-year-old boy came for treatment in September, 1958. He had been fighting a depression for about two years by drinking and provocative acting out. After each episode of acting out, he felt guilty and became even more depressed than before. He had enjoyed the summer in the company of five other young people at a summer community where his parents had taken a cottage. Among his companions was a girl who was 'going steady' with someone else, not present at the summer community. Although he knew this, my patient permitted himself to become fond of her and with her had his first petting experiences. When the summer was over he was disappointed and angry that, although she continued to see him and pet with him, she retained her other boy friend as her first choice. As the Christmas vacation approached, A attempted magically to recapture his pleasure of the previous summer by inviting to his home for a weekend stay his five companions, from several different cities, including his teasing girl friend. A few days before they were to arrive, he determined to tease her by inviting, for an evening of the weekend, a girl he had recently met, who was known to be somewhat loose in her behaviour. By necking with this second girl in the presence of the first, he would make her jealous. He told me of this plan with glee, on Wednesday, the day before Christmas. He also told me that he intended to borrow a car and drive it illegally. Immediately thereafter he became restless, reported that he had nothing more to say, and wanted to leave before the end of the session. 'I know you must think I'm a terrible person.' Although he acknowledged that his anger was due to

projected guilt, he was so angry with me that he clenched his fist and struck his hand with it repeatedly while at church that night, and his parents noted that he was surly during the Christmas observances at home. He explained that he was angry with me because I was, after several months of observation, able to watch him do something improper. He compared it to his sitting at a microscope at school, watching an amoeba, and impatiently waiting for it to split (n.b.). He skipped his session on Friday.

On Monday evening he told me that the weekend had gone badly, or at least had seemed to go badly. The car that was to be borrowed wouldn't start. The new girl who was to make the old one jealous didn't show up. Even though he spent several hours petting with the latter, and many more in conversation with the whole group, he remained depressed during most of the weekend. It seemed to him that too few people came to the party he gave on Sunday and that no one enjoyed himself. 'When I looked in the mirror this morning, my face looked like a mess', he said, referring to his acne. ' My shoulders looked too narrow, so I put on a heavy jacket.' We had previously ascertained that he had been troubled for some time by concern that he was not well built and not attractive, and that his concern in this form was a displacement from concern about the inadequacy of his genital. After the session we discovered that it had begun to rain. I suggested to A that he call his mother and ask her to drive over and pick him up by car. No, he would walk home, the rain wasn't too heavy. It was a ten-minute walk. I learned in the following session that as he was walking through a wooded area alongside a pond, he felt weary and stopped to lean against a tree. He felt that he would just like to stay there, and at the same time he could visualize an image of himself continuing to walk home. ' I wanted just to stand there and let another part of me carry on.' A few moments later he continued on his way. In response to a question, yes, he had wanted to die. The patient was embarrassed as he related the incident, and blushed. He thought such an experience might be a sign of mental illness, perhaps schizophrenia. Lukianowicz reports that several of his patients too were embarrassed as they reported autoscopic experiences. I am not sure whether my patient's experience was merely vivid fantasy or actual hallucination. From his self-consciousness I would infer that it was the latter.

That night A had a dream which he unfortunately reported only at the end of the next session, so that there was no time to ascertain the details or to obtain associations. There was a small body of water separated from the ocean by a narrow sandy isthmus. It was A's task to tow a rowboat from the ocean side onto the sand with a small automobile. He could not manage the automobile. Instead of a steering wheel, there was a bar that one twisted with one's hands. I can provide some of the probable associations. The marine locale refers to the resort spot where he had enjoyed the companionship which he had attempted to recreate in his weekend reunion. The lake alludes to the pond, alongside of which he had wished to remain and die. The isthmus refers, by a phonic association, to his girl friend. The car he could not drive refers to the one he had intended to drive illegally but which did not become available to him. The dream wish, I believe, is the wish to be reborn. The attempted rebirth failed, because he could not adequately control his penis in masturbation, and was not able therefore to master the girl. The fact that the pond next to which he had stopped and wished to die appeared in the dream, suggests that the dream repeated in some way the autoscopic experience which had occurred several hours previously. The patient was still depressed at the session on Tuesday evening when he reported the autoscopy and the dream.

When I saw A again on Friday he was still depressed. He was no longer simply concerned with self-degradation, but was indulging in fantasies of leaving home, going to a distant community where he would find and live with an elderly couple who had no children, and where he would prove himself by working for his room and board, and by succeeding at school. This was a fantasy of rebirth by leaving his parents and adopting other parents. A recalled that as a small child he had wondered what things would be like if he were the child of other parents. In that case, he had thought, he would necessarily be another person, so it made no sense to continue with such ideas. Meanwhile he had written a letter to his girl friend expressing his anger with her openly for the first time, but he wrote courteously and temperately and intended with this letter to discontinue the relationship.

On the following Monday, A reported that he had enjoyed the weekend. His parents had been away and he had been told to spend his time as he wished, without supervision. The only advantage he had taken of this freedom was to come home an hour later than usual on Friday night. He had given some thought to what he would do if his parents were killed while they were away on their trip, whether he would continue to live at home with his little sister or go to live with relatives. Then he had considered the possibility of drawing up some kind of written agreement with his parents whereby he would promise to do everything expected of him, and they in turn, would stop their close supervision. Finally, toward the end of the session, blushing and with some embarrassment, he related another autoscopic incident. Saturday, as he sat alone reading, it seemed to him that ' another one of me goes to the medicine chest and takes an overdose of sleeping pills '. Again it was difficult to ascertain the exact quality of the apparition because of his embarrassment. ' I could see this fellow standing in front of the medicine chest pretty clearly ', he said. The patient recovered from this period of depression by becoming reconciled with his parents.

Notice that this case is consistent with Freud's observation that the appearance of the double is a harbinger of death. In each of these two incidents, one of the two images wished to die: in the first instance, the patient himself wished to die, while his double went on home; in the second, it was the double who went to take the sleeping pills, while the patient remained sitting in his chair. In the second instance, the experience followed the fantasied death of his parents. In each case the patient remained stationary while the double moved away from him. In most of the case reports I have seen the observer is stationary and the double moves towards or away from him. Lukianowicz reports three cases that were neither organic in origin nor schizophrenic. His first patient was a woman who had retired from teaching because of a nervous breakdown. Her autoscopy began when she returned to her home from her husband's funeral. The second patient had lost a leg and finally was run over by an electric tram under circumstances that lead one to suspect suicide. (It is interesting to note that this man had observed that his double could walk through solid objects such as doors. He died by walking into the tram.) The third patient developed the phenomenon two years after he became aware that he suffered a diffuse sarcoidosis which was invading all the tissues of his body.

That rebirth, as well as death, is one of the aims of the autoscopic experience is illustrated by this case. Both the dream and the fantasies that followed the first incident of autoscopy demonstrate the strength of the rebirth wish. The same association is evident in his comparing himself, *before* the first autoscopic incident, to an amoeba about to split. The association between rebirth and loss of identity occurred to this boy, and frightened him, even in childhood, when he considered the possibility of having other parents.

To this point my observations have served to confirm Freud's few concise remarks. My chief point is somewhat different. In recent papers (11) I have tried to show that the libido content of the ego, that is, its potential of libidinal energy, may be estimated by means of certain clinical criteria. Depressions can be classified according to whether they are associated with a high or low level of erotic energy in the ego (12). In the former case we see an unhappy patient who strives to end his unhappiness by some kind of acting out. In the latter we see an inactive patient, or in the extreme case, a patient with melancholia. When there is little or no erotic energy available to the ego, its tonic and object directed functions can be maintained only by the energies of the death instincts. In other words, in such melancholic depressions there is a true instinctual defusion. Another characteristic of melancholic depression is that external objects cease to exist for the patient. To the extent that objects or their effects are appreciated, they are seen as virtual introjects. The ego knows only itself, and that not as an object, but merely as the experiencer of sensations. The loss of erotic energies has permitted the ego to collapse back into a state of primary narcissism. However, the object loss which precipitated the depression, and the energy deficiency in the face of continuing superego and environmental demands, cause great discomfort, and this, in turn, evokes the energies of the death instincts. We have then, in melancholia, an ego suffering great pain, eager to act to destroy something or someone in order to eliminate the pain, but 'knowing' only itself as the source and seat of the pain. The suicidal tendencies are the only possible result. In the ego-depletion depressions which are less intense than real melancholia, the situation is similar though less pronounced; some object-directed ego libido remains.

What does this have to do with autoscopic phenomena? When I considered the material of Case A, I was reminded of Freud's suggestion (3, p. 54): 'Is it not plausible to suppose that this sadism is in fact a death instinct which, under the influence of the narcissistic libido, has been forced away from the ego and has consequently only emerged in relation to the object?' But where, owing to ego depletion, primary narcissism prevails, as it does in melancholia, or to a lesser degree in milder ego depletion depressions, there are no libidinal objects. It is for this reason that projection is infrequent in melancholia. When it does occur, it consists simply of displacing the delusional illness upon someone else, but there is no consequent interest in the object, as there is when the schizophrenic attacks his persecutor. In the ego-depletion state, projection can be used only defensively, and not as a mode of entering upon a libidinal object relation. It occurred to me that when, in this state, residual libido (or perhaps, defensive death instincts) attempts to deflect the activated death instincts from attacking the hurting ego, it could encourage them to employ projection. The source of the pain, the disappointing ego, the unattractive

body, the demanding superego, the suicide impulse, any of these may be projected out. In the absence of a psychically valid object, the projection is manifested only by an hallucination. In some instances the ' bad ' fragment remains, while the ' good ' fragment is projected out. For example in Case A, the suicidal image was projected out in the second episode, but the hopeful image was projected out in the first. In short, it seemed to me that the autoscopic phenomenon occurred in states of primary narcissism associated with ego energy depletion, when the activated death instincts attempted to force the source of pain outside the ego. I found this view confirmed, but obviously less original than I had thought, when I encountered a statement in Freud's paper on ' The Uncanny ' (2, p. 236) written at about the same time as ' Beyond the Pleasure Principle,' to the effect that ' doubling ' is partially to be attributed to ' the urge towards defence which has caused the ego to project that material outward as something foreign to itself '.

I must add to the account of the case material, therefore, that my patient was in a state of ego-depletion depression, that is, a mild melancholia, during the week when these two autoscopic incidents occurred. The evidence for this opinion is: (*a*) a preoccupation with inner sensations and less with visible attributes (primary as opposed to secondary self-observation); (*b*) lowered self-regard; (*c*) relatively little concern with objects; (*d*) general inertia and unusual difficulty in getting up in the morning; (*e*) pessimism; and (*f*) guilt. These are clinical variables which I consider indicators of dearth of libidinal energy in the ego (9). The fantasied attempts at recovery and the rapid actual recovery indicate that this state differed from a true melancholia in that the ego depletion was not fixed, but was repaired as quickly as a suitable opportunity for object relation appeared.

If the reader will grant my contention that at the time of his autoscopic experiences the patient's ego was in a state of relative libido depletion, he may still question whether this state was necessary for the phenomenon, rather than fortuitously present. I think I can support the thesis with my second case.

Case B: A 29-year-old unmarried woman had been in analysis for nine years except for an interval of almost two years between the ages of twenty-four and twenty-six. Her analysis was plagued from the very beginning by a tendency to silence which also characterized her behaviour in all her daily life. She would spend session after session in complete silence. It was this impenetrable resistance which induced us to discontinue the analysis at the age of twenty-four, content with the improvement we had already obtained. Depression forced the resumption of the analysis, but it went no better after resumption. No interpretation which I could devise, or which was suggested to me by an older colleague, prevailed against the silence barrier. Nor could I terminate the analysis, because the threat of suicide was growing as time was passing. In 1957 I had begun to use a few of the newer tranquillizing and energizing drugs to overcome some of the most serious technical difficulties I encountered in analysis (11, 13, 14). This resistance seemed to me to warrant such an unorthodox approach. Accordingly, in October, when the patient had just returned from a month's vacation in Europe, I prescribed 2 mg. daily of perphenazine (Trilafon) and gradually increased the dose to 12 mg. a day. The patient responded with irregular but definite increase in psychoanalytic production which was readily handled in analysis and which led to her understanding and accepting the erotic aspects of the transference for the first time. However, to my dismay, I saw a steadily increasing depression, preoccupation with thoughts of death and suicide, dreams about these, anorexia, insomnia, lethargy, lowered self-regard, and increased self-criticism. Finally, on 9 January the following event occurred. ' Thursday night I looked into the mirror. There was a buzzing sound in my ears. I saw an illusion. There was my image in the mirror, but what was behind me, the doorway, was not reflected in the mirror. The image in the mirror was telling me—I read in its eyes—the fastest way to get everything over with was to go into the kitchen and kill myself by turning on the gas. I didn't want to hurt anyone else so I decided not to do it. I ran out of the house onto the street and walked a long time before returning.'

Here then is a case of autoscopic hallucination occurring for the first time, in a patient under analytic observation for seven years, apparently induced by a tranquillizing drug. That is, the experience occurred in a state of ego depletion which was induced by the drug. Had the patient not been immersed in primary narcissism because of the dearth of available libidinal energy which could seek an object, I believe the need to discard a part of herself might have been satisfied by a primarily libidinal projection onto the object. For example, consider the following incident which occurred toward the end of December 1958 when the patient was not under drug influence; her depression was mild to moderate, irregular, but accompanied by her usual bulimia, which I believe may generally be taken as a sign that ego depletion is threatening, but has not yet occurred. She attended a cocktail party to which she had been invited. She received few such invitations and had hoped, perhaps, to meet a young man with whom she could establish a good relation.

She did meet a young man, but as she had done on several similar occasions, she went to bed with him on the same night. ' After intercourse, the more I looked at him, the more disreputable he became. He'd been acceptable up to that point. It was as though the contact with me had changed him. At one point I got up and looked into the mirror. I saw a pretty girl. I didn't look like I'd been drinking or having intercourse. I was untouched and completely without feeling—empty. I couldn't have respect for him now after intercourse. I felt contempt for him—and for myself. I suppose everything I felt for him I felt for myself. . . . On Saturday, I didn't want to wake up and face myself.'

Certain questions now require discussion. Clearly the combination of primary narcissism and ego depletion is not a sufficient condition for the occurrence of autoscopy, for this combination is seen frequently in psychiatric and psycho-analytic practice, while autoscopy is seldom encountered. Both these patients were prone to deliberate, self-conscious self-observation. Even when not depressed, they would speak about watching themselves in a dissociated way. They tended to look at their mirror images as one might look at other people. Some indications of a tendency to ego splitting have already been noted for case A. The evidence in Case B was considerably more extensive. There were numerous reports of conscious self-watching and self-observing. In addition, it was not unusual for the patient to say that she felt far away, separated, empty, unfeeling, unreal and not herself. In both of these patients, therefore, there was tendency for the ego to split into acting and observing fragments. Perhaps this tendency is also a necessary condition for autoscopy. Freud, who reported the single incident of autoscopy I mentioned above, certainly had a remarkable capacity for self-conscious self-observation, which he exploited in an astonishing way. My experience with my two patients suggests that in analytic session, the self-observing fragment identifies with the analyst and attempts to scrutinize the acting fragment; the former, however, itself resists analysis, and by entering enthusiastically into a compact with the analyst attempts itself to avoid scrutiny. Thus both patients would report to me fairly objectively what they had done, but were defensive about their feelings before, during, and after any acting out. It was the refusal of the observer to communicate her judgements and feelings that made for the frustrating silence of Case B.

We are led, then, to the subject of self-observation. I have tried to distinguish between the self-observation consisting simply of awareness of one's inner feelings, coenesthetic sensations and affects, which, following Nunberg (7a), I have called primary self-observation, and the observation of oneself as an object, with the perceptible qualities of external objects (9, 11), which I have called secondary self-observation. The latter occurs normally when the ego is adequately supplied with energy by the libidinal instinct. The former is seen in the state of ego depletion. His physical appearance and those attributes visible to others are not considered by the patient with the melancholia-like depression, except to the extent that he may try to get rid of his pain by projecting what he considers to be its source, from his ego onto his body. In his hypochondria, the melancholic is concerned with dysfunction of internal organs which cannot be seen. The schizophrenic hypochondriac, on the other hand, speaks of having twisted eyes or pigmented skin or some other deformity, visible to others. (Many schizophrenics are also in a state of partial ego depletion so that their clinical signs and symptoms are not clearly to be distinguished from those seen in melancholia. A full discussion of this problem is beyond the scope of this essay.) One may perhaps say that the self-observation of the archaic ego, in its primary narcissism, is exclusively primary. As the archaic ego acquires psychic energy from the libidinal instincts in the course of its maturation, it becomes interested in objects and in itself as an object, rather than as a locus of sensation. That is, it acquires the capacity for secondary self-observation and secondary narcissism. In the state of secondary narcissism, the ego-ideal comes into being, and it becomes associated with the secondary self-observation of the ego, then forming the complex which is called the superego. In the shift from primary to secondary self-observation, the self-observing faculty becomes dissociated from the acting ego. When, as a result of disease, ego energy content exceeds normal limits, typically in paranoia, the self-observing faculty is projected outside the ego altogether, onto the object. This state in which self-observation is projected outside, I have called tertiary self-observation.

Let us return to the subject of autoscopy. Patient B suffered in her hysterical state of partial ego dissociation, which occurred in the presence of an adequate or excessive ego energy supply. As the energy level was reduced by the

drug, secondary self-observation gradually gave way to primary self-observation and the ego split tended to resolve. For a while, despite the reduction in ego energy, the patient was made happier by the integration of the ego. As the ego depletion became more severe, it became more painful. Finally, in extreme pain which induced a wish for self-destruction, the ego attempted to save itself by reverting once more to its defensive tendency to split: the critical self-observing and self-punishing faculty was split off from the ego. Since, however, neither secondary nor tertiary self-observation was possible, a hallucination was employed. Paradoxically, autoscopy is not really self-observation. It is a magical process by which an image of the self is rejected instead of the real self, in the same way as the primitive man will kill his adversary by injuring an effigy. The effigy is constructed not to examine or illustrate the adversary, but to dispose of him. One may even say that autoscopy is an attempt to terminate self-observation when self-observation is intolerable.

In autoscopy, the hallucinated image of the self is generally disliked by the observer. Freud (2) commented on this fact and suggested that the dislike arose from the ' uncanny ' effect of seeing one's double. It seems to me that it is the dislike which impels the autoscopy in the first place. The image of the self is disliked and therefore projected out. When the image is seen outside, it is still disliked, and probably, as Freud remarks, more so, because it is a double.

While the projected image generally represents a repudiated aspect of oneself, in some instances, it is the ' good ', the hopeful, or the feeling part of oneself. We have noted this inconsistency in Case A, and I mentioned above my suspicion that the division of roles between retained and rejected fragments was related to the more constant condition that the observing self was stationary and the hallucinated image moving. Now in some of those instances in which it is the ' good ' fragment which is projected out, a feeling of depersonalization occurs (Lukianowicz (5), Cases A and F) which resolves when the autoscopy terminates. In other instances (*ibid.*, Case B) the union of self and image is associated with a feeling of unreality. Which of these two relations prevails apparently depends upon whether the projected fragment is the repudiated or the ' wholesome ' one. In either case it is clear that the depersonalization is a response to rejection of a portion of the ego by the faculty of self-observation. It is a manifestation of the defensive tendencies of the death instincts, just as negation is (4). Although autoscopy occurs, I believe, only in a condition of ego depletion, depersonalization is encountered when there is a defensive tendency to ego splitting whether the ego energy content is somewhat inadequate, normal, or excessive. It is interesting that in his paper on Depersonalization, Nunberg (7) includes an instance of autoscopy (Case 2). Depersonalization, as a means of repudiating certain images or fragments of the ego, occurs briefly in nascent schizophrenia, but the high libidinal pressure forces the schizophrenic ego to take others or itself as pseudo-objects onto which it projects these fragments of the psyche. Depersonalization can appear recurrently or over relatively long periods of time, days or weeks, in hysteria. It may be noted at the beginning of melancholia, or in mild melancholia, but once serious depletion of libido has ensued, no observing faculty in the ego can ordinarily become detached from the rest. When, however, in melancholic-type disturbances autoscopic splitting occurs, it may permit depersonalization.

One final point of interest. Two schizophrenic patients whom I have been following closely through relapses and remissions experienced visual hallucinations and illusions when I treated a relapse with a phenothiazine tranquillizer. These visual disturbances followed an initial quieting effect, lasted no more than one to three days, and disappeared days, weeks, or months before full reality testing was restored. In the case of one of these patients, visual illusions occurred also on one occasion, when a nascent relapse gave way to a mild submelancholic depression, probably as a result of analytic work, or at least without the use of a medication. This last observation indicated that the effect was not a toxic one. I would surmise from these several observations that libido withdrawal from the ego, whether occurring in the depression syndrome (12), or induced by phenothiazine tranquillizers, proceeds in such a way that the instinctual derivatives resident in the nucleus of the ego (9, 10) override the visual percepts conveyed to it by the ego supplement (l.c.), so that visual distortion or hallucination appears. Such a surmise would be consistent with and would help to explain my conjecture that early, or mild to moderate, enervation of the ego is a necessary condition for autoscopy.

In summary, hallucinations or illusions in which an image of oneself appears, are encountered in conditions in which there has been a depressive withdrawal of object and self cathexis, and also a diminution in ego libido content. This combination of psychic events occurs in melancholia, some schizophrenic states, and some instances of neurotic depression. Autoscopy is also more likely to occur in individuals who tend to use ego splitting as a defence. The autoscopic experience represents an attempt to fracture off from the suffering ego the fragment which is felt to be the source of pain. The dearth of libidinal energy precludes projection of this fragment onto an object, while the prevalence of primary rather than secondary self-observation deters simple ego splitting with depersonalization. The latter, however, may accompany autoscopic splitting. Dynamically, autoscopy is a manifestation of wishes for death and rebirth.

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PREPARATION FOR ANALYSIS[1]

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With the increasing popularity of psychoanalysis, we might be deceived into believing that individual resistance to analysis has diminished. However, people still do not know what analysis really is, and the popularity of such clichés as the great value of catharsis and the importance of releasing aggression and hostility has only introduced new and more subtle resistances. Furthermore, if we consider that the originally very limited indications for analysis have been greatly expanded in recent years, the resistances must have multiplied correspondingly. With increasing frequency analysts accept patients with weak or crippled egos, not particularly because of the excessive therapeutic ambition of the analyst, but because there is no other method available to strengthen a weak ego and to reduce an ego deformity, whose extent often is in inverse proportion to the will to recovery. The fact that we now accept such patients makes a through preparation for analysis even more imperative than before, when only psychoneurotics and a few non-neurotic cases with an urgent will to recovery were accepted.

If we focus on preparation for analysis, we have to consider that the first impression which the patient gains from his future analyst will be of prime importance. The patient might have followed a momentary counterphobic impulse to consult an analyst and might already regret his courage. However, if given ample time to scrutinize the analyst and perhaps to compare him with previous therapists and other significant people in his life, it will lessen his anxiety and increase his curiosity instead. Therefore, the initial or diagnostic interview should preferably be a two-hour interview. This also gives the analyst a better perspective from the start. Freud began analysis immediately by imparting the fundamental rule to the patient before he started relating his story. According to Freud, 'a systematic history telling should not be expected from the patient and never be encouraged; every piece of the history will later be told anew' (5). It is true that the patient, throughout his subsequent analysis, will recount details of his biography, but they will come piecemeal; to ask him for a consecutive narrative then will certainly be non-analytical. On the other hand, the repetitions with the various elaborations, improvements, and distortions of the patient's original story will be a valuable guide for the progress of the treatment. Apparently, Freud's greater concern was to keep his new method free from contamination with conventional psychiatry, a matter about which we no longer need be apprehensive. The initial interview for psycho-analysis cannot differ from an ordinary psychiatric consultation, especially since it will depend on this interview whether psycho-analysis or psycho-analytic psychotherapy will be recommended.

To avoid unnecessary repetition, Glover advised limiting history-taking to the non-referred cases (6). But aside from the fact that practically every patient we see is referred, the referred patient could be told: 'I have heard about some of your difficulties, but I would like you to tell me about them in your own words.' To the patient this can only mean that his words are given full credence, and that his own concept of the psychic experiences leading to the consultation is the only valid one.

Of great practical value is a careful inquiry into the patient's relationship to the referral source and into what, if any, preparation he has received from that source. Many false notions about analysis may be revealed and corrected in this way.

When the patient consults an analyst with an established reputation, and is referred by him to a younger analyst, this alone acts as a preparation, and some part of the reputation of the

[1] Presented at the Annual Meeting of the American Psychoanalytic Association, Philadelphia, 25 April, 1959.

older analyst will reflect upon the younger colleague. Though the referring analyst might consider the case hopeless and only be relieving himself of a burden, he still contributes essentially to the favourable outcome of the case by his mere statement that he considers his younger colleague highly competent. Even if the patient is referred after only one or two sessions, but especially if he appears for re-analysis, it is advisable to forget about free associations, and, first of all, to get a clear picture of his feelings concerning his former analyst, the reasons for the discontinuance of the old therapeutic relationship, and his feelings about the new analyst in comparison with the old one. Otherwise he will continue to carry over certain negative feelings which will interfere with the progress of the analysis. The new therapist also would miss an early opportunity of recognizing certain mistakes made by the former analyst, which he himself would be liable to repeat. It should be a routine procedure to inquire about open and camouflaged transferences to previous therapists, and then to attempt to probe for current transference potentials.

In regard to free associations, the patient as a rule might need some reassurance. Actually, by complying with the fundamental rule he is doing the very opposite of what he has learned since early childhood, because the person to whom he would confide everything that comes to his mind might use this knowledge against him. The analyst, however, as a neutral observer and a physician, will utilize this knowledge only for the patient's own benefit. No person is capable of complying effectively with the fundamental rule of free associations in the beginning of an analysis, since many people cannot even express their ordinary ideations. Therefore, the patient should be told that he need not be agitated if he finds that he cannot follow the rule to perfection. When the time has come at which he is able to verbalize his associations without deletion and criticism, he will be well on the way to the end of the analysis. Even at the definite end of an analysis the optimum 100 per cent of free associations are never produced.

To circumvent impulsive acts, for instance that the patient might prematurely and abruptly stop the treatment, the analyst must not omit to instruct him that the fundamental rule also refers to his impulses, and that he is supposed to verbalize every impulse before he carries it out. He can then also be prepared for periods of strong resistance, and told that at times he will feel like running away because something is stirring him up. However, if he will stay in analysis until whatever wanted to break through has passed the barriers of resistance, he will no longer feel the need to run away. It is not too infrequent for a patient, already in the beginning phases of analysis, to wonder anxiously how well he is doing and how much longer the analysis will last. Lionel Blitzsten used to reply to such a patient: ' It took you 35 years (the patient's age) to get as sick as you are. I shall not be able to blow it away in a few hours.'

Ultimately, the patient should be prepared for the most frustrating feature of analysis, the analyst's silence. A good approach is to inform him about the policy in regard to questions. In the beginning the analyst will ask many questions, but as the analysis proceeds, he will ask fewer and finally none. This will not mean that he has lost interest or that the technique has changed. On the other hand, at times the patient might want to ask questions. Some of these will be pertinent, and for that reason will be answered. Some, however, will not be answered, and not without reason. The analyst may not even know the answer, or the patient may know the answer himself. At times it will actually be more important to discover the purpose of his asking the question than to answer it. Often the analyst will know the answer quite well, but the time will not be suitable for telling it to the patient.

Preparation for analysis is an endeavour to which no arbitrary limit can be set. Even after the patient has taken to the couch there may still be a period, lasting from a few weeks to some months, which can be regarded as preparation for analytic work. This puts the old controversy over the use of the couch into a new focus.

According to Reik, the seemingly insignificant fact that the patient talks but does not see the analyst sitting behind him, creates ' the atmosphere which transforms a sober situation into a magical one '. It is the couch that ' works magic in this age of modern technical achievement ' (9). Other leading analysts are of the opinion that it is never too late to put the patient on the couch, but that it is very often too early. Robert Knight has cautioned that ' the technique of free associations in relative isolation on the couch, with the analyst taking an impersonal, inactive, listening role, invites autism and regression in the patient ' (7). He limits this procedure to patients with enough ego strength to keep the therapeutically-induced

autism and regression controlled and temporary. However, there are other borderline patients with such powerful aggressive tendencies that a therapeutic intervention is possible only in circumstances which keep their aggressions against the therapist temporarily under control. These are patients who welcome a face-to-face interview as an invitation to verbal wrestling in which, of course, they expect to be superior and to defeat the therapist. In such a situation, the relative isolation of the patient on the couch will itself serve as a preparation for analysis. (One might even permit a patient to sit up again after this has been accomplished.)

Eissler, discussing deviations from the basic model technique of psycho-analysis, mentions Fromm-Reichmann's analysing in a face-to-face situation as a deviation, or, he calls it, a parameter. He enumerates other parameters, and then warns against the ready introduction of parameters by which the therapist may only cover up his inability to use properly the interpretive technique, which Eissler considers the only tool of classical psycho-analysis. He also states that ' every introduction of a parameter incurs the danger that a resistance has been temporarily eliminated without having been properly analysed ' (3). Without going into the validity of Eissler's statements, one gets the impression that in many instances he may have taken it for granted that these patients with whom the parameters were introduced were really in analysis, and hence analysable. What he considers as deviations from the classical technique may have been only a variety of attempts to make a person with severe ego modifications accessible to the technique. In other words, these were methods of preparation for analysis and not the analytic procedure itself. Eissler refers to the patient with the hypothetically normal ego who in clinical reality is never encountered. Such an ideal patient, after some introductory instructions, will immediately associate freely without any deletion and criticism and will make maximum use of the interpretations given by the analyst. The average patient, and especially the patient with ego modifications, will need a much longer preparation than the initial interviews can offer. Therefore the treatment cannot immediately be analysis *per se*, but will gradually turn into it as the patient's anxiety diminishes and the slightly supportive, encouraging, or promoting activity of the analyst tapers off. Frequently what in outward appearance may be regarded as a classical analysis of many years' duration may not even have scratched the surface, but nevertheless may have made the patient accessible to a future analysis by another analyst. Ruth Mack Brunswick writes in reference to the re-analysis of the Wolf-Man, ' I believe that the insight won during the first analysis was responsible for the patient's final accessibility ' (2).

The first analysis, however, may also, and without the awareness of the therapist, reduce the prospects for re-analysis.

A 32-year-old physician, an ambulatory schizophrenic with persistent homosexual phantasies, had, of his own accord, written to his previous analyst abroad to send me a resumé of his analysis with her which had lasted about five years. In her letter to me she described him as a patient not easy to treat because ' he loves to talk and a lot, but he produces only few memories and even less from his childhood, and his productions are without affect '. From my own experience with him in the course of three months, I concluded that she must have permitted him for years to deliver an uninterrupted, relentless flow of verbalizations, seemingly in compliance with the fundamental rule and yet only an expression of a most tenacious resistance. As far as I could hear, he did not hold back any memories, but, under the pretence of revealing significant childhood material, he indulged in an endless recital of infantile reminiscences and autistic reveries of megalomanic content. He was quite complacent about being ultra-honest and a model patient. He regularly brought numbers of voluminous dreams and was very proud of his fantastic productions, by which he had seduced his mother, his previous analyst, and so far me as well, because by giving him interpretations I was not only actually applauding him, but also affording him an opportunity to show me that he knew everything better than anybody else. He had consulted nearly a dozen analysts before he came to me. In his phantasies he had defeated all of them because they had all proved incapable of dealing with him. He had carefully checked whether I was a classical psycho-analyst, which unconsciously meant that I would cater to him and not interfere with his illness. In one of his dreams, the analyst was lying on his belly, while he the patient, as Apollo, the beautiful muscle boy, was stepping with one foot on the analyst's buttocks.

To paraphrase Fenichel, ' a reasonable ego from which this pathological conduct could be alienated was lacking, analysis was in principle impossible, and a preanalytic pedagogical training was required to establish such a reasonable ego ' (4).

The first thing I did was to tell him that he made quite an understatement if he considered himself merely neurotic. He understood the

implication and correctly guessed that I wanted to induce anxiety in him. Nevertheless, he was unable to fend it off, and tried desperately to prove to me that he was only playing with psychotic phantasies. He suggested a Rorschach test, but to his surprise I accepted and welcomed his suggestion, which made him even more apprehensive. Then I told him to stop talking about Greek drama and mythology, about Moses, Leonardo da Vinci, and Goethe, and instead to tell me about his work in the hospital and how he was preparing for the Medical State Board examination. When again he began the next hour with a dream, I told him that he need not tell me any more dreams since he did not profit by them. For the first time he was silent for a while, obviously startled. Then he accused me of not conducting a classical analysis. I replied that he still had to be prepared for analysis. This certainly did not sound like praise or admiration. Therefore, he now wanted to sit up so that he could see by my facial expression whether I really meant it and, in case I did, to cry on my shoulder and let me reassure him. This confirmed my suspicion that letting him sit up would not make him more analysable. I had actually cut off most topics for his associations, and I could not have done this if I had not known the enormous narcissistic investment which he had in speech, so that it was utterly impossible for him to be quiet for any length of time. We must not close all avenues for a patient; we must leave some outlets, better more than one, for the expression of pathology. Therefore, when the patient declared that he had nothing to talk about, I did not interpret this as spite, but suggested that he talk more about his megalomania. In the following weeks I used the most powerful analytical tool, complete silence. It seemed to be effective. He began to study for his State Board examination, which so far had been beneath his dignity. Hour after hour, by enumerating his omnipotent wishes and phantasies, he discovered, by himself, that his megalomania was ubiquitous. He developed the insight that he lived in a fantasy world in which people were only shadows, and he their master. He came to the conclusion that it was good for him that all his big talk made no impression on me, while he still could get rid of it. He could not talk about it to his previous analyst, because whatever was not a dream was considered unimportant. Soon, however, he could no longer tolerate my silence, not because of his need for interpretations, to which in any case he did not listen, but because of his excessive need for applause, or at least for verbal encounter. Though I gave him again some directives and some scanty interpretations, he became increasingly aggressive, accused me of wasting his time and his money, because for the purpose of talking to himself he need not come to the hour. He finally insisted on sitting up and throwing his incriminations straight into my face. At this time I resorted to another parameter, a drastic reduction of the frequency of interviews. It was less for the purpose of ' bringing his dependent needs vividly into consciousness ', as recommended by Alexander (1), but rather to demonstrate that he had over-estimated my dependent needs relative to him. It was not an ' improved strategy to shorten the most prolonged part of the treatment, the tedious middle game ' (1); I had not deceived myself into believing that the treatment was past the preparatory pre-analytic stage. I told him quite frankly that he could not count on projecting the masochistic component of his sadomasochism on me. Of course, I also knew that he was extremely lonely; therefore, confronted with the alternative of scarcity of hours or scarcity of gratifications in the hours, he would certainly choose the latter. After six weeks of a reduced schedule he implored me for more hours, and I was able to resume the previous four hour a week schedule. At the end of a year he expressed spontaneously his gratitude that I had not thrown him out, his appreciation for the patience with which I had dealt with his persistent provocations, and his feeling that despite himself I shall be able to analyse him.

Another man in his late thirties, with multiple phobias, was referred to me after an unsuccessful analysis of four years' duration. He was supposed to utilize what he had learned in his analysis, but instead had only regressed further. Therefore after an interruption of several years the previous analyst had refused to take him back into analysis. To this patient, analysis meant, in the literal sense of the word, getting another doting parent, who would show intense interest in all the elaborations and displacements of his fears, and would reward him for his inactivity and lack of initiative. He had to learn that as long as he did not manifest a will to recovery by exposing himself to the phobic objects, the analyst would refuse to show the intense interest for which he was craving. Therefore, he was seen only in one hour a week face-to-face sessions for a year and a half preparatory to the subsequent reanalysis, which ultimately proved successful.

In relation to classical phobias, Eissler writes, ' Despite maximum interpretation, the pathogenic area cannot be tapped; even if the patient ideally adheres to the basic rule, the area constituting the core of the psychopathology will not become accessible ' (3). This can only mean that analysis has not yet really begun. Jorge Mom went so far as to analyse an agoraphobic woman for three years in her home (8). We may think of the joke of the analyst carrying his couch on his back making a house call, but it would be a misnomer to call this psychoanalysis. The phobic's persistent fear of impending death keeps him in a state of panic in which he cannot be analysed. By spreading and displacing the thanatophobia on to a variety of phobic objects, he succeeds in diluting it and turning it from something inescapable to something escapable. He then, however, has to hold tenaciously to these phobic, priceless objects, and the analysis threatens him with their loss. So he will implore the analyst not to take the phobia away from him, or will turn the analyst himself into a phobic object. At any rate, before phobic patients can be analysed, they need a long period of preparation for analysis. The following case may serve as an example of how this can be done.

A 40-year-old surgeon, accompanied by his younger brother, consulted me because of his overwhelming fear of impending death. A tall and husky man with harmonious features, he wore a sports shirt and, instead of a tie, a black cord of Western style, held together by a medallion. His fear of death began when he was bending down one day and felt like fainting. Then he became increasingly frightened of the compensatory pauses following the extrasystoles by which he had been bothered for twelve years, and was convinced that he had also the precordial pain of angina. His attacks of extrasystoles occurred mainly when he was driving his car. Therefore, he carried liquor in the car and avoided streets which had associations with his cardiac arrhythmias. He was in the habit of taking afternoon naps, but suffered from insomnia at night. He was a victim of hay fever; he had symptoms of acrophobia, and recently had become practically impotent. But aside from his pretty and devoted wife, he also had a mistress, a nurse. His mother, a very excitable woman who dramatized every illness in the family, was still alive. The patient had two children, boys. He neglected his surgical practice and frequently had to interrupt operations from fear of fainting; once during an operation he was actually given oxygen. For four months he underwent pharmacotherapy and took enormous amounts of drugs, including narcotics. He reported a repetitive dream in which he was parking his car in one of three parking lots and, when he returned, did not remember in which lot. It needed no associations to recognize from the dream that he was uncertain with which of three mothers, his mother, his wife, or his nurse, he should park himself.

I let him go on the couch in the third hour because I felt that I should emphasize the difference from his previous drug therapy, which he euphemistically called psychotherapy, and create distance between him and me because of his pressure of speech and his devouring tendencies. He talked at length about the drugs he was taking, and reported a dream in which he was on a beach where children were playing basket-ball. Thus, he dreamt that he was on vacation or in retirement, and one of the children. Soon he spoke about his preoccupation with death, how tremendously upset he was about the early death of Tyrone Power and another movie star, and how much he was frightened by the death cycle in his practice. He spoke so rapidly that it sounded as if death were on his heels. He mentioned that he read newspapers from beginning to end, but avoided reading the obituaries. While the hero dies only once, he was afraid of dying every day. I remarked that it seemed that he was taking death *in dosi refracta* every day, and I asked him if he expected me to vaccinate him against death. At the end of the hour, I told him that he could read the obituaries, and if he found his name, to call me. He could not help laughing at this on leaving.

The following hour he began with an unofficial part in which, standing in front of the couch, he told me that he wondered why I showed no interest in his drugs, that he had decided no longer to see his previous therapist, and that he was going to cut down on the drugs. ' But what should I do with sleep?', he asked. ' I still cannot sleep enough.' And with this he took to the couch, beginning the official part of the hour. He complained that he had only three hours' sleep and was excessively concerned about it. Then he spoke mockingly about his blind faith in analysis, because I had told him that it is just as specific for his illness as an appendectomy for appendicitis. On leaving, he again asked what to do for his sleep, and I replied he should analyse his thoughts while lying awake. His retort was that his thoughts were to kill me, and I answered that he could analyse that too.

In the eighth hour I told him that he was a

drug addict and interpreted his sleep phobia as part of his death phobia, and that he seemingly had no choice between dying in his sleep and dying from not sleeping. It occurred to him that he never wanted to sleep in a pitch-dark room; it represented a tomb. After this hour his wife called me and told me that he kept the whole family in turmoil with his insomnia, and asked me desperately what to do about it. I advised her to ignore it and no longer to try playing his nurse. In the following hour he expressed his anger that every prop had been pulled away from him. He reported a dream in which he had to stop in the middle of the sex act and it occurred to him that a famous actor had died during coitus. I told him to stop his afternoon naps, since he was no longer a child, and to read a medical journal when he woke up in the middle of the night. He was perplexed about my nonchalance and persisted in fretting about his insomnia, until I asked him whether he had no other gramophone record. Finally, I interpreted that he imitated his grandfather who supposedly had a stroke and retired at the age of 40 (the patient's age) and subsequently lived until the ripe age of 82, so that he would reach the same age. After about six weeks of treatment, he approached a crisis because he had scheduled a major operation. He came to the hour with his wife and she asked how she should deal with his panic about performing surgery, and I replied, in his presence, that she should ignore it. She said that she had always submitted to his wishes, but now did not know what to do. I advised her to reverse the situation and, for a change, to tell him her needs and her wishes. When I was alone with him again, he called himself a ' sad bastard '. He had had 18 patients the evening before and, in the end, felt like fainting. I said: ' You were envious of your patients, and your fainting spells are experiments by which you want to control death, so that you would be the only one who would never die.' When he still went on dramatizing his fears, I asked him whether he ever wanted to become an actor. He was surprised how I knew this and admitted that he always thought that he had such a beautiful physique that one day one of the Hollywood scouts would be sure to discover him for the movies. I told him that maybe he thought he was Tyrone Power. In the next hour, he reported triumphantly that he had performed a major surgical procedure without any difficulties and felt that he had made a real step forward. By the end of the second month he stopped imploring me for help and could even tolerate my remaining silent through a whole hour. I had the assurance that he had become analysable.

What were the methods I had used? By putting him on the couch as early as the third hour, I acquired enough therapeutic detachment to counteract his panic. As Daniel Silverman remarked in his discussion of this paper, it was just the let's-get-to-work attitude which, because it pulled him out of his panic, was helpful in this case. Owing to the popular concept of the couch, I established immediately a clear distinction from pharmacotherapy, which he was still undergoing. Therefore, it was not necessary to tell him to stop seeing the pharmacotherapist, he did so of his own accord. With ' external firmness and limit-setting ', as advocated by Knight (7), I reinforced his weak inner controls and at the same time checked his progressive tyranny, which had been encouraged by the over-permissiveness of his environment. As much as he dramatized, I devaluated his fears, mostly by ignoring them and even telling his wife to do so, which was active interference. In that sense I attacked the core of his psychopathology, his secret delusions of omnipotence and immortality, and the defence which he had put up to maintain them. By an abundance of early interpretations, premature for an analysis, I met half way his desire for an omniscient parent. Given the opportunity to identify with an omniscient and omnipotent parent, he could give up his own cravings for omnipotence. I omitted deep interpretations, such as his sadistic concept of coitus, and his sexualization of surgery, to avoid stirring him up prematurely, but I declared him an addict for the purpose of arousing a new form of anxiety, and a realistic one.

Summary

To summarize, we may ask when preparation for analysis is completed. So far as the analyst is concerned, it is completed when he has a bird's eye view of the dynamics and is able to gauge the transference potentials of the new patient; and, furthermore, when the analyst (*a*) is certain that the patient will not stop treatment at any time convenient to him, and (*b*) is relaxed enough to need no longer to make plans or to speculate about devices for making the patient analysable and keeping him in analysis. The patient is prepared for analysis when he has overcome his panic or acute

distress, but still suffers enough to be motivated to accept the frustrations inherent in the analytic procedure. One must be able to detect in his free associations a trend to alienate himself from the pathological part of his ego. The patient must be in the process of projecting his own omnipotence onto the analyst, and at the same time trying to become worthy of this new omnipotent parent. Then, by re-introjection, after passage through the analyst, a healthy remodification of the patient's ego will take place.

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THE ROLE AND RESPONSIBILITIES OF THE PSYCHOANALYTIC CONSULTANT

By

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Recently Abercrombie (1) lecturing on ' The Art of Consultation', noted that ' consultation is not simply a question of sending a patient away for a second opinion. It is the careful selection of the man who by training and temperament is the most suitable for the matter in hand. His position in the profession, his standing in his specialty, his skill, his appearance, his manner, and his gift of tongues have all to be considered.' In the practice of medicine and its non-psychiatric specialities, consultations are ' arranged, generally speaking, either for information or for action,' though often of course for both purposes (1). The emphasis here seems to be on assistance to the original physician as well as to the patient.

Increasingly greater numbers of patients are being referred to psychiatrists and psychoanalysts for consultations and recommendations. The importance of this aspect of our work, though appreciated by many, has not been formally considered as a specific role up to now. The term consultant, as used in this communication, will refer to the analyst who is contacted for a patient-evaluation, and suggestions for further procedures. His role is not that of the therapist, although some therapeutic activity is inevitable even in such a transient relationship. The therapeutic activity of the consultant prior to referral to the therapeutic analyst will vary with the presenting situation, the type of patient, and the consultant's attitudes. If the consultant becomes too active therapeutically without intending to be so for a specific purpose, this can seductively sabotage later work. This may be due to an unresolved difficulty of the consultant that reflects itself in an inability to really ' let go' of a patient, or to an unconscious depreciation of the potential therapeutic analyst. On the other hand, therapeutic planning with the patient can be quite helpful. The unconscious reaction of the patient even to the single contact with the consultant can be very important. The consultant, though unable to plan his consultation completely, must none the less be aware of his role. Thus the question that must be kept in mind is the flexibility of the consultant's role and his attendant responsibility. The technique that is followed will vary with consultants and their feelings about the specific patient.

The initial question to be considered is how the patient gets to the consulting analyst. The motivation for help on the part of the patient, though very important, will not be considered in detail here. The patient may come to the analyst on his own, or the actual referral may be made by other physicians (non-psychiatrists, psychiatrists, analysts), former patients or relatives, auxiliary medical personnel, or by community agencies. Patients frequently defer seeing the consulting analyst even after deciding to do so, until an acute threatening episode arises which confronts them with an overwhelming crisis, whereupon they seek that long delayed appointment. Inquiry into details of the referral may yield important clues as to the motivation, anxiety level, and resistance patterns present. Fantasies about psychiatry and analysis may then be elicited, as well as the expectations and goals of the patient.

The first major responsibility of the psychoanalytic consultant is to evaluate the patient's problems in order to ascertain what his difficulties are, the capacity for communication, the genetic pattern, the degree of ego resiliency and integration, the capacity for further growth and development, and the amount of limitation that reality imposes on the therapeutic regime. In short, the consultant has to decide what can be done for this person with his particular difficulties in a specific reality situation based on his individual developmental pattern. The amount of time needed for this evaluation varies;

however, if it extends beyond two to three sessions, subsequent referral may be contaminated. Patients do have transference reactions to the consultant. How he handles these will be important for later work.

Once an impression is reached on the basis of the diagnostic interviews, the question of recommendation arises. This is the second major responsibility of the consultant analyst. He must decide whether he will undertake the treatment of the patient. If he cannot do this and if further therapy is indicated, the next step must be referral. He must communicate his suggestions to the patient, the responsible members of the family on occasion, and perhaps to the source of the initial referral to him. Areas of complication may occur at this juncture. Strong patient and relative resistance may be encountered. This may be posed as reality-anchored, but since the consultant has presumably considered reality factors in arriving at his decision, these may be viewed as manifestations of resistance. This resistance may be voiced directly by the patient or indirectly by sensitive relatives out of their own ambivalences. In other instances, this responsible relative (spouse, parent, child, sibling) may be sufficiently threatened to voice his own objections, despite the patient's desire to abide by the consultant's recommendations. If the anamnestic interview has stirred up too much threatening anxiety, the patient may balk at further investigations into his problems. The consultant must be aware of these and handle them with the patient and the family.

When the consultant will not be treating the patient, he is in an excellent position to deal with these anxieties, hostilities, and resistances directly. He cannot be accused rationally of having a vested interest, and therefore can directly make suggestions that the therapeutic analyst might wish to avoid. In addition, the consultant may suggest evaluation and therapy for the relatives or may act as a continuing figure who can later be contacted by the family when questions arise. It is recognized that this may have adverse effects, but on occasion this recognized role of the consultant can facilitate the subsequent therapeutic regime.

On occasion, the analytic consultant is expected or requested to inform the original referring source of his findings and suggestions. This again may be an area of complication, depending upon the ability of the referring source to accept what the consultant advises. In the case of the physician who has an unconsciously hostile attitude to analysis, sabotage of the therapeutic planning may be anticipated. Further referral for psycho-analysis may arouse competitive feelings in the original referring source. These should be understood and dealt with whenever possible. Again, if later complications arise, and the original referring source is contacted by the relatives, the consultant analyst can once more be a source of information regarding the patient, and/or the therapeutic process without intervening directly in the one-to-one analyst-patient relationship.

If psycho-analysis is advised, it is incumbent upon the consulting analyst to discuss the question of fees and time arrangements with the patient. Such therapeutic planning can facilitate later work with the therapeutic analyst. Questions which may indicate deeper resistances, or which may indicate a need for more superficial support, can be handled at the explanatory level. It is sometimes necessary to talk with the financially responsible relative at this point so as to avoid later complications. The consultant again is in an excellent position to deal with this issue as he will not be involved in the later therapy. To be sure, these problems may come up in the patient's analysis, but the irrational aspects of them will be more clearly delineated.

A clinical example may illustrate this point more specifically. A twenty-year-old college student sought psycho-analytic consultation because of anxiety in connexion with his relationship with women. His father, though sympathetic to this idea, was consciously resistant to it. In fact, it was rationalized as concern about the degree of pathology present in his son. The consulting analyst, working with the father on one or two occasions, kept the therapeutic relationship with the therapeutic analyst uncontaminated and allowed for the development of a smoother transference neurosis on the part of the patient. Later the patient was most grateful for this method of procedure, as he always felt father was spying on him, and initial contact between father and the therapeutic analyst might have reinforced this partially realistic fantasy. Once the father's anxiety was alleviated, no further external interference occurred.

The last major responsibility of the consulting analyst is the selection of a therapeutic analyst for the patient. We know that no two analysts are identical, and yet both can be well analysed

and well trained. We cannot hold the fantasy that the analyst is perfect. Thus we must attempt to recognize, study, and anticipate the significance of the personal characteristics of the prospective therapeutic analyst on the analysis of the patient. Some patients may request an analyst of a particular age, sex, stage of experience, ethnic-cultural group, or geographical location. The consultant must evaluate these requests carefully to understand, whenever possible, what their underlying meanings are. One woman requested that the consultant refer her for therapy to a male analyst around fifty years of age. The patient could not consciously explain the reason for this request. However, the later analysis was in large part concerned with her longing and unresolved mourning for her father who died at the age of fifty. She had never fully accepted his death, and hoped in analysis to continue the father-daughter relationship where it was fixated by father's death (2). Thompson (4) notes that patients' preferences can be manifestations of resistances and defensiveness. She cites specific cases where the age, sex, personality, and cultural background of the analyst were made into initial attempts to handle particular conflicts by the patients. Thompson focuses on the psychoanalytic significance of the choice of the analyst by the patient. It is important to bear in mind that such patient requests may not be merely manifestations of resistances, but may have some validity. It is an accepted fact that familiarity with a particular cultural background will permit the analyst to appreciate certain value systems, customs, and attitudes. In instances where there is a bilingual background, familiarity with both languages can be an asset. Without such appreciations by the analyst, things might be misunderstood or thought of as having undue pathological significance.

The selection of the therapeutic analyst is usually a matter for the consultant. The motivations for this referral may not always be conscious ones. There are many factors involved in the selection of a particular analyst for a specific patient. The reality factors are of initial importance. These include the availability of the analyst, the economic range of the patient's resources, and the geographical location. If these are not involved, other considerations such as age, sex, marital and parental status, experiential and cultural background of the prospective therapeutic analyst may be important. These latter prerequisites may be less important if there is excessive pressure on the consultant to find a therapist quickly. When there is more latitude, we may find that certain analysts are excluded because of their temperament, attitude, interests, capacities, or too many similarities to significant past or present figures in the patient's life. If the consultant has had actual contact with the prospective therapist, he is in a better position to evaluate his skills and liabilities, though biases, blind spots, and unresolved transference and countertransference reactions between consultant and therapist may work adversely in the selection of a therapeutic analyst. G. and M. Piers (3) have called attention to the identification that the consultant may make with the therapeutic analyst selected. This implies that the choice of a therapeutic analyst relates itself to that aspect of the ego ideal of the consultant which is concerned with how this particular patient should be handled. Such a relationship between the referring and the therapeutic analysts may be important in the later therapeutic process. A colleague, in noting a particularly gratifying therapeutic relationship with a patient, commented on how he felt positively toward the patient even prior to the first interview. In reflecting on why this was so, he speculated that his positive feelings and admiration for the referring analyst might have set the tone for the subsequent activity. The transference-countertransference relationship between consultant and therapist may be observed in many ways if one looks for it. When there is a communication bridge between therapeutic and referring analyst, after therapeutic analysis has started, anxieties—unconscious or at times conscious—about performance on the part of the therapist may be detrimental unless worked out. At times consultants are motivated by the thought that particular patients will or will not stir up anxieties in a specific therapist, or lest the patient be so uninteresting as to initiate boredom in the analyst. These considerations may not always be cognitively spelled out, but when one focuses on the motivational factors involved in the choice, the pre-conscious components may emerge. As already mentioned, the therapeutic analyst may have conscious or unconscious feelings about the referring source that may present a barrier in the analysis of the patient. A case of this is the premature referral of a patient to an analyst by his own previous analyst. The therapeutic analyst may in such an instance have such personal feelings about this

case as to impair objectivity. In supervisory cases, where training institutes are the referring sources, similar anxieties about performance may be more frequent than appears in the literature. To date no reports of investigations of such reactions in candidates have been published, nor has the question of specific rationale for case selection for individual assignment to candidates been reported.

The manner used by the consultant in giving information to the prospective analyst may also be quite revealing of the attitudes of the referring analyst. Thus the initial question of availability may already indicate the degree of interest the consultant has in the patient. Is the patient given a list of several analysts to call and find one that is available, on his own, or does the consultant call them himself and refer the patient to the doctor who can definitely see him? After referral does the referring analyst request periodic reports because of research interest? Does the therapeutic analyst ask for a supervisory relationship with the referring analyst? What does the referring analyst say to the prospective therapist? The answers to these questions serve to illuminate the area of the motivational factors in analyst selection. Ideally, the prospective analyst should be allowed the opportunity for a free choice of patients independent of loyalty and obligation to the referring analyst. In the main this is so; however, one does see certain lines of referral set up which may be based on unconscious irrational motivations. An example of this may be the constant referral to analysts either analysed by the consultant, or to ' sibling ' analysts who had been analysed by the same analyst as the consultant. The rationale for this may be quite valid, but then again it may warrant further introspective investigation.

In conclusion, I would like briefly to discuss the patient's reaction to the consultant after the therapeutic analysis starts. On occasion, the consultant is retained in the background as a figure to whom the patient can return for counsel or further referral if necessary. Thus the patient cited above, who lost her father, defended herself against the paternal transference with the fantasy that if the analyst died, he could be replaced by another with the aid of the consultant. Patients may fantasy various relationships between the consulting and therapeutic analysts. They may also have reactions of anger, feelings of rejection, disappointment, longing, or satisfaction about the referral. When these feelings are not reinforced by actual interventions by the consultant, they are worked through in the analysis and their significance to the patient is understood. A woman who was very competitive with her younger brother for father's attention had as a first dream in her analysis the following: ' Dr Z. (the consultant) was a king. Although I am his oldest child, I am sent by him to the much younger and inferior crown-prince to get permission for something.' In this instance the response by the patient to the referring and therapeutic analysts, and its relationship to the patient's earlier life, seemed clear and was confirmed later on in the emerging transference neurosis.

Summary

An attempt has been made to delineate the role and responsibilities of the psycho-analytic consultant. These include patient evaluation; communication of recommendations to the patient, responsible relations, and/or the original referring source; and, the selection of a therapeutic analyst. Various components and areas of complication in this consultative role are discussed.

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ON BASIC UNITY

By

MARGARET LITTLE, London

The Editor regrets that by a typographical error the last three paragraphs and references of Dr. Little's article on pp. 377–384 of this Volume were omitted. Their text is as follows:

Freud quotes Robertson Smith (*Kinship and Marriage*, 1885) ' Identifications which lie at the root of clan feeling rest upon the recognition of a common substance, and may even therefore be brought about by a meal eaten in common.' Here again we have the substance, the concrete thing, and bodily experience. The Christian idea of Communion rests upon the concrete symbols of bread and wine which are believed to provide a means of resurrection after death, i.e. survival of the body.

I know that this could be understood in terms of relationship of an oral kind, but I want to remind you of the two points from which I started: (i) the attempts made by patients to establish union or identity with the analyst, and (ii) the importance for them of body happenings.

To sum up:

Within an individual both survival and the ability to find objects with which relationships can be formed depend upon the existence of a unity which comes from the entity mother-infant (or analyst-analysand). From it a rhythm of differentiation and reassimilation or integration comes. It provides the ' stillness at the centre ' which allows of movement and perception; it is the *sine qua non* for living continuously in one's body, for having an identity, and for being identical with, and able to make assertion or statement of, oneself.

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OBITUARY

FREDERIC SAMUEL WEIL

1900–1959

Frederic Samuel Weil died on 6 November, 1959, at the age of 59. He left us, who knew him only as strong and healthy, without warning, and his sudden departure leaves an unhealed rift in the structure of our Institute.

Frederic Weil came from an upper-middle-class Jewish family in Basel, his grandfather having left Alsace after its surrender to Germany. The aversion to compromise and the insistence on acting in accordance with conviction so characteristic of him was apparently a family pattern. The grandfather's choice of Basel as a new domicile was most fortunate for Frederic Weil's development. Swiss at heart as is no other city, Basel's northerly geographical situation exposes it to French and German influences also. These left their traces on Weil's personality.

Born on 25 September, 1900, Weil reciveed his undergraduate education at the Humanistische Gymnasium at Basel. Turning for a short time to the study of botany and geology, he soon decided to opt for medicine, and from 1919 to 1925 attended the medical schools of the universities of Basel and Vienna. After taking the Swiss Medical State Board Examination in 1926, he obtained his medical degree the following year at the university of his native city.

His doctoral dissertation was devoted to the permeability of the meninges in certain mental disorders. The necessary research had been done from 1926 to 1927 at Bois de Cery, the psychiatric clinic of the University of Lausanne, where he spent his psychiatric internship.

Thence he went to Kreuzlingen, working there for two years as Ludwig Binswanger's *Assistent*. The responsibilities he had to assume there were, however, far greater than those customarily attached to such an appointment. Binswanger quickly recognized Weil's eminent qualifications, and gave him the direction of two sections of the institution, one of which was considered the most difficult of all to manage. His gift for treating psychotics was acknowledged by his chief, who, when Weil left, expressed his particular thanks for the benefit the whole institution had derived from his collaboration.

The next four years, until 1932, Weil spent at Burghölzli, the citadel of psychiatry in Central Europe. There, on the basis of his superb command of the whole field of classical psychiatry, he wrote his only clinical paper: 'The Conversion of an Oligophrenic Murderer Suffering from Prison Psychosis'. In this publication Weil showed his great skill in presenting an unusual and intricate psychiatric history. He solved the problem of correlating the history of three murders with the religious system developed by the feeble-minded patient under the stress of a frustrating environment.

Avoiding the temptation to get lost in the many fascinating details of the clinical situation, Weil was able to recreate the patient before our eyes as the suffering human being he was, who found bliss and almost ecstasy in a system of religious revelations. We cease reading only with the greatest regret that Weil did not make more use of his rare combination of organizing capacity, impeccable literary style, and scientific depth and exactness.

Weil continued his clinical training at the University Clinics of the Charité at Berlin, and completed it at the Salpêtrière in Paris in 1933.

At the beginning of his medical studentship he had become familiar with some of Freud's books through a much older friend. The latter soon broke with psycho-analysis, but on his first contact with Freud's work Weil had made up his mind to make psycho-analysis his life-long vocation. He remained true to this determination for the rest of his life, difficult as this must have been in the early years when the beginner was offered, in sect-torn Switzerland, a variety of other depth psychologies perhaps more alluring or exciting than austere classical analysis.

He was in training analysis with Emil Oberholzer from 1930 to 1931, and this professional association grew into a long friendship. For years he collaborated with Oberholzer in the latter's Rorschach studies and himself became a foremost expert in the Rorschach test. From 1932 on, Dr Weil was a member of the Swiss

Medical Society for Psycho-Analysis. He was thus well prepared to settle down in Basel for private analytic practice, and he did so in 1933. During 1937 he married his wife Annemarie, with whom he shared profession, interest, and life, and who stood faithfully by his side to weather bravely whatever fate had in store for them.

In 1940 Weil decided to leave his native country, and he emigrated to the United States in the following year. From 1942 to 1947 he was Adjunct Psychiatrist at Mount Sinai Hospital, New York; in 1948 he became Associate Attending Psychoanalyst at the Psychoanalytic Clinic of Columbia University; and in 1949 Instructor in Psychiatry there. In 1946 he gained the Diploma of the American Board of Psychiatry and Neurology.

He was in further analysis with Dr Ernst Kris in the U.S.A. In 1943 he became a member of the New York Psychoanalytic Society; from 1947 on he was a member of the Faculty of our Institute. This function became the area of his main interest, and to it he loyally and devotedly dedicated most of his free time. He held numerous assignments. One—and this he cherished most—was his teaching. He conducted the Rorschach seminar for two years, gave a reading seminar from 1950 to 1956, and thereafter the seminar on the obsessive-compulsive neuroses. From 1952 to 1954 he was Secretary of our Institute, and from 1952 was regularly reelected a member of the Educational Committee. He served on many other committees, and was Chairman of the Student Committee from 1954.

Weil was well known for the thoroughness with which he carried out his duties. He was never ready to make compromises with regard to work he had to do. He unflinchingly set aside his own comfort and advantage in favour of the Institute's welfare. He worked in several key positions, and there are many who derived great benefit from the wisdom of his decisions, his foresight and conscientiousness. But all of us owe him a great debt for having made the welfare of the Institute his main and principal concern. No doubt this was a great sacrifice for him, not only in terms of time and physical exhaustion, but also of renunciation of research work and publication. He was equipped as was no one else to undertake a productive career as a scientific writer. His familiarity with classical psychiatry, the profundity of his knowledge of Freud's writings and the psycho-analytic literature, the vastness of his psycho-analytic experience with the neuroses and the schizophrenias, made him a scholar of a type that in our time is becoming more and more rare. If fate had spared him for a few years he would, despite his absorption in the flourishing of the Institute, have given us, I feel, a critique of existentialist psychiatry which would have been a synthesis of the three fields in which he was an unrivalled master. The contemporary degeneration of Central European psychiatry was for him a matter of worry and alarm. That we did not have the good luck to receive from his pen a repudiation of this latest deviation on the tortuous path of European psychiatry is an irreplaceable loss.

When a Rorschach of the Wolf Man was needed, the Sigmund Freud Archives turned to Weil and asked him to undertake this responsible piece of work. They could not have made a better choice. Interrupting his vacation to meet the patient, Weil not only administered the test but performed a thorough psychiatric examination, thus making a decisive contribution to one of the most controversial issues in psychoanalytic literature.

Weil remained to the end a representative of the so-called classical technique of psychoanalysis, which he employed in a masterly way. Rarely do personality and classical technique harmonize so well as they did in him. Accordingly, it never became a problem for him what technique to use, as happens so frequently. It is often claimed that the coldness of the classical technique alienates the patient and subjects him to unnecessary suffering. The way Weil dealt with patients is an outstanding example of the fallacy of this argument. He proved that humaneness and humanity are not only compatible with even the extreme rigours of the classical technique but are its very prerequisite. It is also my impression that his work showed how adherence to classical technique does not preclude the development of a personal style.

Weil consistently avoided the limelight. His lack of showiness was not the result of a principle, or based on a compensatory mechanism. It was, it seems, part and parcel of his personality; neither the result of conflict nor leading to conflict, but his natural way of living, which was characterized by a deeply meditative relationship to the world. To spend an evening in his company was a source of delight, because the intimacy of personal relationships opened the channels of communication. One then had the

opportunity to admire the wealth of his ideas and the gracefulness of his mind. In the intimacy of personal conversation with him one also discovered what I would call the French tradition in him. Then he was witty, at times ironic, supple, and always extremely sensitive to aesthetic values; indeed, I should consider a subtle kind of inborn aestheticism most typical of him. He possessed an aura of natural beauty of which he was quite unaware because, again, it was not the result of deliberation or principle. The flexibility and fluidity he exhibited in personal contact was in contrast to his unbending determination when it was a matter of doing. He was well known for his unwillingness to make compromises in any decision of a committee on which he served. As a true humanist, he acknowledged freedom of thought in the realm of ideas, but insisted that there is no alternative to the one correct decision that will solve a problem at hand.

Weil was one of the few who succeeded in making a synthesis of seemingly discrepant cultures. His honesty and moral fibre would never have been able to deny any of the cultural loyalities that were part of him, and thus he preserved his personal identity by bringing into harmony the many cultures with which by necessity and by preference he identified himself. Although he grew up in the Germanic part of Switzerland he absorbed likewise the French element of the Swiss tradition. He was a true Swiss if ever there was one, but this did not prevent his becoming a true American when he came to the United States. He soon felt at home here, and although he loved his Basel as much as before, America became for him a second native land, doubly dear to his heart after the birth of his beloved Susan, in whose upbringing in a country that gives its children a degree of freedom undreamed-of by a Swiss child, he intensely participated and found consummate happiness. Amidst this great variety of disparate cultures that he integrated he also felt himself a Jew. Although any trace of orthodoxy or nationalism was quite alien to him, he would probably have approved when the Faculty donated four hundred trees in Israel in his memory.

But overtowering these various cultural and ethnic ties was his cosmopolitan humanism, in which he was again most loyal to the tradition of his native city. Thus the most general and the most special aspects of him coincided, and the harmony he established was favoured by the fortuitous conjunction of external factors.

Among the wealth of memories of Weil that will never leave us, there was one thing that probably made him memorable even to a casual acquaintance: those dark, glowing deep eyes, out of which spoke passion and compassion, suffering and joy, the ancient child and the wisdom of the adult; those eyes were unforgettable by anyone who had ever seen them.

K. R. Eissler.

LEONARD BLUMGART
1881–1959

Dr Leonard Blumgart died on 20 March, 1959 at the age of 78. It was with profound sorrow that we learned of his death. He was one of the pioneers of psycho-analysis in America, and had the courage, tenacity, and faith to begin practice in New York at a time when the atmosphere was not friendly to analysis. There were only a few analysts in New York and none in the rest of the United States.

After graduating from the College of Physicians and Surgeons at Columbia University, Dr Blumgart served his internship at Lenox Hill Hospital. He served as a volunteer at the New York Psychiatric Institute at Wards Island from 1915 to 1920. He was attending psychiatrist of the Out-Patient Department at Post-Graduate, Polyclinic, and Cornell Hospitals.

In the spring of 1921 Blumgart went to Vienna, together with a small group of psychiatrists, to be analysed by Freud, and remained there until the following year. During his career he was also Associate Attending Psycho-analyst at the Psycho-analytic Clinic for Training and Research of Columbia University. He belonged to various psychiatric societies, being a life member of the American Psychoanalytic Association, and a member of the International Psycho-Analytic Association and the New York Academy of Medicine.

Blumgart was very active in promoting the aims of the Child Study Association in its early beginnings, and wrote papers on the mental hygiene of children. He served on the Board of Visitors of Westfield State Farm, Bedford

Hills, New York. He was one of the original sponsors of the Committee for Mental Hygiene among Jews when it was formed in 1919. This Committee formed the nucleus of the Hospital for Mental and Nervous Diseases at Hastings-on-Hudson, now known as Hillside Hospital, on the Medical Advisory Committee of which Dr Blumgart served from 1927 until 1947; for a period he was its Chairman. Later, he became Consulting Psychiatrist to Hillside, and served in this capacity until his death. During this association with Hillside Hospital, Dr Blumgart had an important constructive influence on the Medical Board's activities and in the expansion of the hospital.

He became a member of the New York Psychoanalytic Society in 1914 and instructor in the New York Psychoanalytic Institute in 1938, serving in this capacity until 1950.

From 1942 to 1946 Blumgart was President of the New York Psychoanalytic Society, and it was during his presidency that its present building was purchased and remodelled. During his tenure of office, he gave most generously and tirelessly of his time and energy and contributed his best efforts to help create this permanent home for the Society and Institute.

All who worked with him respected him. He was always courteous, patient, attentive to criticism, always ready to serve and loyally to further the aims of the Society and Institute. A completely sincere and friendly person, with a keen sense of humour and wit, he was an excellent raconteur.

Dr Blumgart had a distinguished career and found fulfilment in his professional, cultural and social life. We have lost a generous, humane friend and colleague to whom this Society and the psycho-analytic movement in the United States owes a great deal. His passing is a profound loss to us all.

Sandor Lorand.

FERNAND LECHAT

1895–1959

The Belgian Psycho-Analytical Society has recently suffered the untimely loss of its President, Fernard Lechat, after a short illness. In him it loses not only one of its pioneers but also one of its most valued members.

Born at Mont-sur-Marchienne in 1895, Fernand Lechat was 19 at the outbreak of the First World War. During the fighting he was badly injured in the legs and left for dead on the battlefield, but recovered and later re-enlisted without hesitation. His numerous decorations are a testimony to his courage. After the war, with his characteristic energy he went into business, but although successful found it was not what he wanted. His temperament, so open to all that was human, led him naturally to the study of other people's problems, with the hope of being able to help them. Attracted by depth psychology, he studied this together with applied psychology, in which he was intensely interested.

During the time when Dr Hoffmann, a pupil of Freud, was staying in Belgium Lechat undertook a professional analysis with him. He then went on to Paris for further work with Dr Leuba and Mme Marie Bonaparte, and was admitted as an associate and later a full member of the Psycho-Analytic Society of Paris.

In January 1947, with M. Dugautiez and Mme Lechat, he founded the Belgian Association of Psycho-Analysts. With his perseverance and unrivalled energy he was able to disseminate Freud's theories in Belgium and to attract young psychiatrists to this new therapy. The task of directing the work of the Association fell mainly on Lechat, who devoted himself to it wholeheartedly, both by writing and lecturing and by editing the Socitey's *Bulletin* and directing the seminars. He was always at the service of his colleagues, young analysts and patients, to whom his time and energy were unstintingly devoted. As an active participant at every Psycho-Analytical Congress, his verve and warmth made him many friends. When, in 1958, he became President of the Belgian Psycho-Analytical Society he organized with his customary enthusiasm the 20th Congress of Psycho-Analysts from the Latin countries.

Those who knew and appreciated Fernand Lechat's vitality, his smiling good humour, and his *joie de vivre*, will miss him greatly. His wife loses an admirable husband; others lose a prized and faithful friend; his pupils, a stimulating teacher. All, even those who disagreed with him, will sadly miss a collaborator whose thirst for knowledge and passion for discussion inspired them to a clarification of their own opinions and to discussion of his. It will take time for us to become fully aware of the fact that he is no longer with us.

Th. Jacobs van Merlen.

BOOK REVIEWS

Human Potentialities. By Gardner Murphy. (New York: Basic Books, 1958. Pp. 340. $6.)

It is a chastening experience for a psycho-analyst to read this book; chastening both because its conspectus is so much broader than that to which he is accustomed in the consulting-room, and because the psycho-analytic standpoint seems to play so relatively minor a role in the thinking of the very eminent psychologist who is its author.

Murphy's courageous, ambitious, and timely aim is to consider the future potentialities of man, or rather to outline a system within which it would be possible to attempt such a consideration. His theoretical standpoint is that of Lewin's field theory of interaction between organism and environment, with the result that he holds that it is not possible to make long-range predictions of what human nature will be like in the future. This broad conclusion is in general convincing, particularly if one inclines to the anti-historicist position of Popper.

At times, however, Murphy seems to take this conclusion too far, as when he suggests that we can have no reliable ideas of what men will be like in the not too distant future. This follows from his relative lack of concern with the biological basis of human nature; and this is the reviewer's major criticism. In psycho-analytic terms, he seems to see the ego as potentially much more autonomous than the id. The question arises too whether field theory, which sees human nature in terms of interaction between organism and environment, can accommodate the unconscious which is cut off from two-way interaction with the internal ' environment ' of the ego as well as with the external one by the barrier of repression. Certainly Murphy does not discuss this aspect of interaction between the human organism and its environment.

He does, of course, acknowledge the importance of psycho-analytic contributions to the understanding of human nature, even though, in his preface, he includes psycho-analysis along with other themes such as atomic energy and its uses, world government, the new pharmacology, on which ' others can write a great deal better. . . . It is the human stuff that concerns me '. It might be asked why one should wish that his acknowledgement of psycho-analysis should more deeply inform his work. Yet his aim is to outline the broadest possible systematic approach that will include within its scope as wide a range of human potentialities as might be conceived. The omission of reference to psycho-analytic studies is particularly noticeable in his discussion of the psychological boundaries between person and world, where he states that contemporary psychology offers at least three approaches, namely those of gestalt psychology, information theory, and Lewinian field theory. This may seem to be ungrateful quibbling over what is an admirable and opportune attempt, but its very sincerity and humanity call for an honest and critical appraisal. Murphy is pioneering and his work challenges the supplemental efforts of, *inter alia*, psycho-analysts.

The book is a manifesto that psychology has and will have contributions to make to the human future just as significant as, indeed more so than, those of physics, engineering, and biology. ' For even though we work within the pavilion of a tightly controlled group process, we can nevertheless give greater and greater support to the growth of individual potentialities. Indeed, if the spirit of discovery, so central in science and discovery, can be made dominant in our attitude to human nature itself and to the individual child, our scientific-technological age may achieve as much creativeness in dealing with the development of its own potentialities as it has achieved in studying the potentialities lying hidden in the world of physics and chemistry ' (p. 174).

Murphy distinguishes three human natures: the biological, the cultural, and a third which is characterized by the need to understand as such and which is a recent development, first showing itself in Greece, again at the Renaissance, and ever increasingly in our own time. He maintains that biological evolution will continue through such means as different matings and racial mixture, changes in nutrition and the understanding of genetics. To the reviewer this reads vaguely and is unconvincing. Physical anthopologists like LeGros Clark have emphasized that it is just man's lack of physical evolution, the retention of his generalized, unspecific anatomy, that has facilitated his mental evolution. There have been no great changes in man's physical nature for the last two or three hundred thousand years, and all the mental evolution that has occurred since then may be fully explicable in terms of cultural continuity rather than in terms of genetic changes. However, Murphy is concerned mainly with the second and third human natures, especially the latter. He sees a new kind of humanity emerging, rooted in science and the urge to discovery, including the discovery of the self, the results of which will strengthen the moral, intellectual, and social drives, e.g. ' He not only finds out more about how he is made, but is changing himself in the process ' (p. 12). The break-through of this new humanity could be described in terms of the conceptions of ego-

autonomy; though Murphy does not consider this possibility when he remarks, ' Gratefully here we may use Aristotle's . . . entelechy, the efforts of gestalt psychology, of Kurt Goldstein, of Gordon Allport, to find fulfillment in the wholeness of the living individual ' (p. 323). This omission of any reference to Freud or other psycho-analysts is not unique. Freud's name does not occur in any of the lists of noteworthy men to whom Murphy refers. When he does refer to him in this sense it is to state that his and Darwin's ideas, ' magnificent and liberating as they are, will . . . have to be replaced by radically different conceptions ' (p. 327).

The concluding pages of the chapter on boundaries between person and world carry, to the reviewer, a somewhat mystical flavour which is perhaps understandable as belonging with the emphasis on the potential limitlessness of human evolution that pervades the whole study.

This is a very stimulating book the reading of which is in the nature of a corrective experience for a psycho-analyst.

Noel Bradley.

Personality, Stress and Tuberculosis. Edited by Phineas J. Sparer, M.D. (New York: Internat. Univ. Press, 1956. Pp. xviii+629. $12.50.)

This book, whose publication is sponsored by the American College of Chest Physicians, consists of thirty-three lectures given by different authors to the staff of the Veterans Administration Tuberculosis Hospital, Memphis, Tennessee, as an orientation course in the psychosomatic approach to tuberculosis. The editor has purposefully avoided any attempt to bring together the different views in the several papers, whose quality varies greatly. Some will be of immediate interest to those psycho-analysts who are analyzing patients who have had or have the disease: especially those by Wittkower and by Hartz.

Wittkower finds that though no specific personality type prevails in tuberculosis patients they all show an inordinate need for affection together with conflicts over aggression. He distinguishes five ways in which the patients-to-be have defended themselves against these needs and impulses and relates each to the onset of the disease, to the patient's reaction to it, and to his tendency to relapse. He quotes with approval Rebner's suggestion that not infrequently the tuberculosis lesion is felt to be representative of and equivalent to the image of a frustrating, sadistically attacked, incorporated mother who is simultaneously craved for. Hartz expresses a similar view.

The insistent and overt demands for affection of some tuberculous patients seem to have led some psychotherapists to make their gratification a first stage in psychotherapy as distinct from general hospital care and management. Masserman seems to hold this to be a necessary prelude to gaining the patient's confidence. Yet the dangers of this approach in intensive psychotherapy are perhaps indicated in a case described by Galdston. A young woman who had earlier divorced her husband fell ill with active tuberculosis, anorexia, and schizoid symptoms after she had suggested to him that they re-marry. Galdston states that initially ' She required not to be told, but to be made to feel that . . . she was in effect a " loved child " in the sight and presence of the therapist. She needed to be " made a fuss over " ' (p. 181). Considerably later ' the transference neurosis was exhibited in pure form ' (184), a claim which in the circumstances just mentioned seems somewhat doubtful. The end-result of therapy was that she re-married her ex-husband. Galdston doubts how satisfactory the marriage could be, but reflects that perhaps it was as much as could be hoped for. One wonders, however, if she may not have re-married against what she may have unconsciously felt were her therapist's wishes, thus repeating the first marriage to the same husband which had been against her parents' wishes. Certainly the therapist's unenthusiastic response when reporting this aspect of the case might well point in this direction. If this were so it may well have been due to the earlier ' fussing over ' phase having made it difficult if not impossible to analyze the transference, and possibly also the counter-transference, in all its ramifications. Perhaps the use of a social worker in that phase, bringing about a split-transference, might avoid such difficulties.

Noel Bradley.

Hypnosis and Related States. By Merton M. Gill and Margaret Brennan. (New York: Internat. Univ. Press. 1959. Pp. 405. $7.50.)

Time Distortion in Hypnosis. By Linn F. Cooper and Milton H. Erickson. Second Edition. (London: Baillière, Tindall & Cox. 1959. Pp. 206.)

A Handbook of Medical Hypnosis. An Introduction for Practitioners and Students. By Gordon Ambrose and George Newbold, Second Ed. (London: Baillière, Tindall & Cox, 1959. Pp. 276. 27*s.* 6*d.*)

There has been a revival of interest in hypnosis since World War II. It is gratifying that psychoanalysts have been in the forefront of those who have re-examined the psychodynamics of the hypnotic state and of hypnotherapy. The book by Gill and Brenman, which has the subtitle ' Psychoanalytic Studies in Regression ', is the most important comprehensive work in this field since the studies of Schilder and his associates. Hypnosis is viewed as ' a particular kind of regressive process which may be initiated either by sensory-motor-ideational deprivation or by the stimulation of an archaic relationship to the hypnotist '. In emphasizing the importance of sensory deprivation, the authors have followed Kubie and Margolin. The hypnotic state implies a reduction of ego function. The transfer-

ence relationship to the hypnotist is of a primitive regressive type. The hypnotic state is ' a regression in the service of the ego '. In their metapsychological consideration the authors have adopted Hartmann's and Rapaport's concept of the autonomy of the ego. In hypnosis there is a loss of autonomy with domination of a subsystem of the ego by part of the environment. Hypnosis also implies a regressive revival of earlier child-parent relationships. The physiology of the hypnotic state is reviewed in the light of recent experimental work. There are interesting chapters on fugue and hypnotic state, and on ' brain-washing '. The latter attacks the sensorimotor apparatus and at the same time introduces a strong transference to the person in power. The authors see hypnosis as a useful adjuvant to any psychotherapy. Its success depends on the psychotherapeutic relationship rather than on the quality of the hypnotic state. The authors here sometimes employed hypnosis in psycho-analytic treatment for deepening the transference. The book contains a useful survey of the clinical applications of hypnosis and an excellent bibliography. Although obviously written with great care it is extremely readable.

The fact that Cooper and Erickson's book on time distortion in hypnosis has appeared in a second edition only five years after its first publication, testifies to the great interest which the author's experimental studies have aroused. The first edition was reviewed in this *Journal*, Vol. **37** (1956), p. 497. The basic observation was the subjective expansion of clock time in the hypnotic state so that long periods could be lived through in a few minutes. The second edition contains new observations on the converse type of time distortion, i.e. the shortening and condensation of subjective time experience in hypnosis. It was possible to produce both time expansion and time condensation in the same subject. The book has opened up a new approach to the study of hypnosis and of the experience of time.

The first edition of the *Handbook of Medical Hypnosis* was reviewed in this *Journal*, Vol. **37** (1956), p. 501. The second edition contains additional information about the neuro-physiology and clinical uses of hypnosis. The book will continue to serve its purpose as an introduction for general practitioners.

E. Stengel.

Identity. Introductory Study No. 1. World Federation for Mental Health. (London, 1957. Pp. 46.)

This interesting essay is the work of a Scientific Committee of WFMH consisting of Margaret Mead, Klineberg, Lagache, Line, and Rumke (chairman). The Committee is concerned with the clarification of important concepts in the field of mental health and with stimulating research. They chose the concept of identity because of its relation to many other basic concepts, and defined it as coterminous with personality and individuality. Identity stems from identification. The development of identity and its organization are fully discussed, as well as the concept of empathy. A section headed ' Identity and Group Membership ' deals with group loyalties, group prejudice, the role of laughter in human relations, leadership, morality, identity change, and other social aspects. Nationalism is discussed as a phenomenon of identity with the nation. Ethnological aspects are also considered. In fact, the book deals with all facets of the personality concerned with human relations of all kinds and levels. It is not concerned with the biological sources of personality development.

This is a most valuable report of what must have been a highly stimulating discussion. It would be a pity if the esoteric sound of the title should adversely affect the appeal of this unusual booklet, which is of interest for everybody concerned with human behaviour.

E. Stengel.

Explorations in the Physiology of Emotions. Edited by L. J. West and M. Greenblatt. Psychiatric Research Reports of the American Psychiatric Association, No. 12. (Washington, 1960.)

This congress report should be of great interest to everyone concerned with the physiological concomitants of emotions such as fear, anger, resentment, anxiety, etc. Numerous experimental studies are presented, and in some of them not only the emotions but also their meaning to the persons experiencing them are taken into account. It is gratifying to note that psychophysiology and dynamic psychopathology are no longer regarded as entirely separate fields of study.

E. Stengel.

American Handbook of Psychiatry. Ed. Silvano Arieti. (New York: Basic Books, 1959. 2 vols. Pp. 2,098. Price £8.)

Before World War II the German *Handbuch*, which used to be a monumental encyclopedia consisting of many volumes, was unrivalled as a source book for information and research. Nothing similar has been attempted since. It is doubtful whether nowadays leading experts would have the time necessary for the elaborate critical surveys of which those works consisted. Also, they would be out of date much more quickly than they used to be in the past. However, the demand for encyclopedic presentation today is as great as ever. The two volumes which have appeared under the above title are an attempt at satisfying this need. In the preface the editor states that ' this work represents a serious effort on the part of 111 authors to present the developments, concepts, trends, techniques, problems, and prospects of psychiatry today, in a form useful for both the expert and the beginner, in

which every leading school of thought and every major approach is included '. This is a formidable undertaking, and it is not surprising that the result is somewhat uneven. The editor has not succeeded in enlisting the co-operation of recognized experts in all fields, but a great number of the contributions are authoritative and first class. Others are less satisfactory, and read like essays written in a hurry. The scope and the level of discourse vary greatly; some articles are valuable surveys written with great care, while others are elementary introductions for undergraduates, such as the brief chapter on the ' classic psycho-analytic approach '. Nevertheless, the work as a whole reflects the range of present-day American psychiatry, and will be of help to students and research workers in many fields of mental science.

E. Stengel.

Oedipus and Job—in West African Religion. By Meyer Fortes. (Cambridge University Press, 1959. Pp. 81. 10*s*.)

In this interesting and agreeable essay—an expansion of his Frazer Lecture—Professor Fortes begins by using the myths of Oedipus and Job to illustrate two primitive, but very different, concepts of causality: one in which fate or destiny, the other in which divine justice, governs our affairs. He then goes on to show how each of these recurs in West African religion.

The tragedy of Oedipus lies, not merely in his punishment (by blinding or castration) for the crimes of parricide and incest, but in the way his conscious longing to be a good son is defeated by his evil destiny—which Fortes derives from his unconscious revolt. Moreover, it is his unconsciously determined curiosity which ultimately brings about his downfall, and helps to determine the form of his self-punishment. For this consists in the destruction of the organ of his insight—a point stressed by Fortes, as by Bion in a recent paper.

The story of Job seems—at least at first sight—to be based on an entirely different theory of the cause of human ills. No destiny compels Job to sin against his will, and so to earn inevitable punishment. But he does sin, and in a very subtle way, by being so self-righteous that he puts himself on a par with God. So, after all, his punishment was just. When he sees this and repents, he is forgiven and his prosperity is restored.

Nevertheless, I am inclined to regard the two myths less as illustrations of two different theories of human misfortune than as stressing two different aspects of the same one. This, when freed from the distorting effect of projection, is the belief (which is very largely true) that our lives are determined by the interplay of our ids and our superegos. For there can be little doubt that these are the entities personified in the concepts of destiny and justice—though not always unambiguously. Both Oedipus and Job sin unconsciously; their sin is committed by a repressed or split-off part of themselves, that is, by something from their ids. And for this both are held responsible, and punished, by their superegos.

The greater helplessness of Oedipus in the face of his destiny, or id, would seem to result from the fact that, as Fortes points out, his father really was a bad one. Laius did reject him; and for this reason the ' hostile component in the filio-parental relationship comes to the fore, and is given symbolic expression in the image of an evil Prenatal Destiny which finally destroys its victim '. For this reason, too, I think his superego has an id-like quality, so that the two entities seem almost fused together in the concept of his evil destiny.

The sophisticated European thinks of events as the product of physical causality and conscious rational decision. The West African, as described by Fortes, acts on the same beliefs in his daily life, in which he seeks, by his own efforts, to achieve a normal degree of success in farming, marriage, and procreation. But, like Oedipus or Job, he attributes failure to destiny or justice. In doing so he shows his awareness, at least of projections, of his id on the one hand and his superego on the other. To this extent we may regard him as more aware of psychically real entities in himself than the sophisticated European.

Roger Money-Kyrle.

Of Love and Lust. By Theodor Reik. (New York: Farrar Straus. 1957. Pp. 624. $7.50.)

About eighteen months ago I reviewed Reik's *Myth and Guilt*, and found it so interesting and captivating that I asked for his next book in the hope that reviewing it would afford equal pleasure. Unfortunately this hope has not been fulfilled. In the present volume Reik states that it must be detrimental to remain a close follower of Freud, as he has been for so long. Whilst doing justice to Freud's great work, he compares it to a symphony which cannot be added to. This comparison seems useless, since the composition of a symphony must necessarily be dependent on the inspiration of a genius, whilst scientific discoveries made by a genius can be extended and developed by others, a fact which Freud was always ready to acknowledge. The author does not tell us how he has been able to write a large number of interesting books and monographs which have branched off in various directions and are valuable contributions to psycho-analysis, and have been generally welcomed as such. It is of course possible that the writer made his statement with his tongue in his cheek. However that may be, this product of his freedom and independence is most disappointing.

The volume contains three long works and one short one which have been previously published. The first, which gives this book its title, is based on the thesis that all falling in love starts with hate.

That is to say, the lover begins by hating the object which embodies so many desirable and idealized qualities. The proof of this thesis is drawn out to almost 200 pages without being made convincing as a generally applicable rule.

Next comes a paper on masochism in modern man. Some of the case material is interesting, and the phantasy content to which the author draws our attention deserves more investigation. He also develops the statement that masochistic pleasure contains a rebellious root in that the patient manages to extract pleasure from pain, despite the general concept that pain can only bring displeasure. While rebelliousness may be found in some cases, one wonders why the author has to accompany his findings by the constant reiteration that almost all other analysts have failed to see them. Pleasure in scientific discovery does not appear to be a sufficient gratification for him.

The short paper on being unmarried contains nothing of note except for some interesting anthropological details.

The last section of the book includes a monograph with observations on the Emotional Differences of the Sexes. While quite readable, this contains nothing new for analysts or even for analytically-oriented laymen.

On the whole, the book cannot be said to be rewarding reading, or to come anywhere near what Reik at his best has been wont to offer his readers. One wonders why this collection has been considered worth reprinting.

Hilda C. Abraham.

The Creation of Woman. By Theodor Reik. (New York: George Braziller, 1960. Pp. 159. $3.75.)

Dr Reik brings his original mind and encyclopaedic knowledge to the never solved and apparently always interesting problem of Woman. He draws attention to the pre-history of Adam who, either a widower or a divorcé (from Lilith), is given a helpmate by God. Applying the analytic rule of 'reversal' to the myth Reik comes to the conclusion that the birth of Eve from Adam was really a wish-fulfilment on Adam's part, and that the real meaning lay in Eve's giving birth to both a son and husband. He then brings this wish of Adam into line with the puberty rites which mean a severance from the mother by the pretence that the sons are reborn by the father.

Reik reminds us here of the many myths that dea with the subject, such as that of the birth of Athene from her father's head. His remarks on mythology, drawn mainly from Otto Rank's book, as well as his interpretation of Genesis are both instructive and, as written in his fluent and witty style, amusing. The book closes with an impressive bibliography.

Katherine Jones.

ABSTRACTS

Contents:

The Psychoanalytic Study of the Child, **13**, 1958.

THE PSYCHOANALYTIC STUDY OF THE CHILD (An Annual), **13**, 1958.

Phyllis Greenacre, M.D. (New York). 'The Family Romance of the Artist.' Pp. 9–43.

Consideration is given to the biographies of St Francis of Assisi, Thomas Chatterton, Gogol, Henry M. Stanley, and Rilke, and the dynamics of the Family Romance which is a common feature. The artist's greater inborn sensory responsiveness and capacity to organize sensory impressions lends an intensity to his personal relationships and an ability for empathy which often leads him to a special relation with aspects of the inanimate world which he animates (the field of collective alternates. *Psa. Study Child*, **12**). Precocious development with diminished boundaries between libidinal phases and premature confrontration with an intense oedipal phase may drive the artist to ease the conflictful nature of his object—relatedness by displacement into the field of collective alternates. Rivalry for cathexis between intensely felt bodily states and object experiences may lead to hypochondria and disturbance of emotional relations.

The marked ambivalence of the latter with the tendency to the splitting of images arises from an unusual degree of fusion of phase pressures and their mutual interaction and reinforcement. The prolongation of this state into latency may result in a feeling of difference from his group for which the family romance provides a rationalization and reinforcement.

In some cases the extreme frustration arising from this hypererotized state may lead to compulsive masturbation with phantasies of destructive inventiveness. The compulsive drive for perfection of the artist derives from this masked sadism as well as the need to harmonize it in the act of creativity. These two attitudes may find expression in the family romance.

The identification of the artist with God and Nature may arise in the phallic-oedipal phase through the force of his own body feelings, incomparably greater in the artist, which respond to and cause a kind of amalgamation of body imagery with outer forms in the world. Experiences of inspiration and revelation at an early age often combine elements of awe (phallic) and supra-sensory communication, closely connected with air movements and flying derived from the olfactory elements of the anal stage; states of fusion with the outer world, the oceanic feeling, derive from experiences of nursing.

The mythological figure of the artist–shepherd-boy represents the essential loneliness of the artist and provides a culture background for the sense of hopelessness and degradation and the fantasies of salvation. The sheep in its softness, smelliness, and dumb reliability has special fetishistic qualities. The fetish has a peculiar significance in both religion and art.

The artist's realization of ability to communicate is not so much a narcissistic gratification and recognition as the temporary interruption of essential loneliness.

Leo S. Loomie, M.D., Victor H. Rosen, M.D., and Martin H. Stein, M.D. (New York). 'Ernst Kris and the Gifted Adolescent Project.' Pp. 44–63.

The title of this group project which Dr Kris chaired is in part a euphemism. the artistically or scientifically gifted patients ranging in age from 9 to 36. This report of a work still in progress aims at illustrating Kris's contributions to two themes especially his own, the nature of the artist, and the methodology of psycho-analytic research. The full analyses of these patients were regularly reported for group discussion.

A young mathematician's attempts to ward off nocturnal sexual feeling by a preoccupation with mathematical problems was sometimes disturbed by erotic feelings, and the solution of the problem might be accompanied by orgasm. Contrary to expectation, a successful secondary process type of discharge could be accompanied by intense elementary effects. The analysis showed that affects were permissible only when they had been completely sublimated and defence was directed to warding off competitive impulses which the outstanding ability unconsciously served.

The impingement of the conflict upon the level of performance was traceable only in the fact that the patient sometimes solved problems without being able to visualize how he obtained his results. Kris pointed out that this problem was not covered by concepts dealing with the transformation of psychic energy (neutralization), which neglect the speed of the process. By using a hypothesis in which the rapidity of the transformation would be the central issue, it might be seen to be characteristic of such a

patient to affect a greatly accelerated transformation of energy discharge from primary to secondary process.

In the case of a sculptor it became possible to study the reinstatement of working ability after a breakdown, and hence the reciprocal interplay between defence, impulse, and work in a variety of reinstated activities. Kris noted: ' We are inclined to think that sublimation is a very great distance from instinctual life. . . . What we see here rather is how the instinctual gratification is omnipresent in the act itself so that it is really the gratification of the instinctual side.'

Further aspects of case material and discussion deal with Kris's preoccupation with the reciprocal effects of the special gift on the environment and the environment's effect on the gift. The latter aspect has more frequently been considered in its role of stimulating or suppressing maturation and development. 'We are about to appreciate . . . the influence which endowment may exercise on life experience and particularly the role which endowment may play in facilitating the detachment of ego functions from conflict in establishing autonomy in certain activities.'

The peculiar form which the family romance assumes in the artist, namely the discovery of the talent by an unknown man who takes the child with him, may suggest a specific factor in the object-relatedness of the artist. ' This is somebody who tolerates the masturbatory fantasy and does not object to it. . . . Then masturbation is tolerable; somebody recognizes in this childish play the great genius.' Here Kris emphasized not only the influence of the typical family romance on the development of the talent but also the talent's contribution to the discovery fantasy. This seems particularly significant in the light of Kris's experience of the crucial part played by identification, a part not sufficient to explain the talent but consistently there.

Further comments deal with technical questions involved in group research of this kind.

Samuel Ritvo, M.D., and Albert J. Solnit, M.D. (New Haven). ' Influences of Early Mother-Child Interaction on Identification Processes.' Pp. 64–91.

This report of work which still continues is based on Kris's interests in longitudinal studies and is presented by his co-workers. The environmental influences in a child's development may reinforce inborn equipment or predisposition or they may act in the opposite direction. The investigation relates to Kris's formulation that the child might have different personality characteristics and adaptations if his predispositions were reinforced than if they were toned down by the environment.

Two girls of observed differing dispositions interacting with mothers of markedly differing personalities were the subject of study (by multiple observers representing differing disciplines), from birth for a period of several years. Predictions were made at each step in the study. Evelyne's early needs were easily met and did not impinge upon the mother's deep conflicts. They seemed to dovetail with the mother's best established defences. The balance of the child's perceptual and discharge apparatus enabled her to utilize the object flexibility for gratification. This balance and the particular type of maternal care facilitated her capacity to accept substitute and illusory gratifications. Margaret, because of her sensitivity and irritability, was a difficult child to comfort. This characteristic collided forcibly with the mother's deepest conflicts. Thus the close empathic tie which could later lead to successful internalization was hampered. While Evelyne developed a capacity to use identification as adaptation rather than as a defence, Margaret's early identification processes tended to be fixated at an imitative level, warding off latent trends to respond to new situations with the painful overflow of irritable responses characteristic of her early sensitivity. The child's ability to identify with those aspects of the (later) comforting mother was thus interfered with. It is possible that the imitative behaviour became a special instance of externalization, i.e. the child imitated the mother *in toto*, perfecting a controllable kinaesthetic image of the mother to replace the earlier threatening representation.

The patterns of the early gratification-frustration experiences are deeply involved in the developing capacity of the ego to store memory traces, form illusory gratifications, and prepare the way for fantasy formation and identification, as well as to facilitate the neutralization of instinctive energy. When internalization proceeds by way of a predominantly positive tie to the object, it is more likely to go on to completion than when it proceeds from a predominantly aggressive tie. Observation of these children at the nursery school stage testified to these generalizations.

Anna Freud, LL.D. (London). ' Child Observation and Prediction of Development. A Memorial Lecture in Honour of Ernst Kris.' Pp. 92–124.

Anna Freud took as the starting point of her discussion Kris's 1950 paper ' Notes on the Development and Some Current Problems of Psychoanalytic Child Psychology ', where the theoretical formulations of the 1920s were first shown to have opened up a new field in which observational studies of children could be integrated with reconstructive data to enlarge and enrich the total developmental picture. For this purpose Kris favoured above all the longitudinal study.

Newer technical and theoretical developments, especially the growing preoccupation with ego psychology, impressed Kris with the fluid and often chaotic state of our diagnostic categories, and he therefore worked to place fact-finding in observational research at the service of diagnosis. It became

his ambition ' to recognize . . . symptomatology before it became manifest . . . to spot danger before it appears '—prediction in his sense. He emphasized the greater feasibility of this aim, now that the interaction of libidinal and aggressive drives in typical danger situations, the ' use of certain mechanisms of defence to certain situations and certain developmental phases ', the adaptive function of defence, and the ' uniqueness of the mother in human life ' could be taken into account, above all to deepen understanding of the stages in ego and superego development. In paying tribute to the work of the Child Study Centre at Yale, Anna Freud named three factors which nevertheless make prediction hazardous; neither the quantitative factor in drive development nor the environmental happenings can be estimated and predicted; and whenever the rate of maturational progress on the side of ego development and drive development is uneven, unexpected and unpredictable deviations from the norm will follow.

Miss Freud here recorded three short studies of her own intervention in early childhood disturbances where observational data had a decisive function.

The problem of intervention is, however, scarcely ever simple. Kris's longitudinal studies have highlighted two further factors: progressive variations in the attitudes of a single mother at varying phases of her child's development which became telescoped and superimposed in the composite and conflicting mother imagines met in the child's analysis; and the infant's reaction to depression and emotional withdrawal in the mother. Even certain knowledge of future pathology in such cases may leave us gravely at a loss in prescribing prophylactic action.

In turning to Kris's contribution to the understanding of the sublimatory process (neutralization of drive energy, and interaction of ' the reservoir ' and ' the flux '), Miss Freud presented three short studies illustrating the difficulty of distinguishing in the immature child between the beginnings of true sublimations of lasting value, sexualizations of ego functions and activities, and compulsive interests which initiate pathology. She concluded ' Perhaps . . . it is not the sublimatory process from which we can take our cue, . . . we have to look for our evidence to accompanying circumstances and conditions in the total picture of the personality.'

A final section deals with the assessment of traumatic events in a child's life. Kris was clear that the traumatic significance of an event was not laid down from the time of its occurrence, but ' the further course of life seems to determine which experience may gain significance as a traumatic one '. Material in this field gained from the parents is weighted according to the parents' and not according to the child's internal stresses. Miss Freud presented a series of studies comparing biographical and analytic data on the same child and concluded: ' I agree with Kris that we cannot predict from outside observation and at the time of occurrence which events will prove important for future pathology . . . which aspect of a given experience will be selected for cathexis and emotional involvement.'

Heinz Hartmann, M.D. (New York). ' Comments on the Scientific Aspects of Psychoanalysis.' Pp. 127–146.

From the outset Freud saw psycho-analysis as the basis for a comprehensive psychology. Scientific analysis is not limited to the use of the analytic method but to an expanding field of application by which it is in turn enriched. Still its theoretical complexities, dictated by the special features of its subject matter, cannot yet easily be resolved by translation into the language of related fields (such as brain physiology), alluring as the greater concreteness of such languages may be.

Within its own methodological field, the interrelatedness of hypothesis and clinical fact-finding is seldom simple, and communication is frequently inexplicit, even misleading, in defining this interrelatedness. But as not even the simplest statement on unconscious processes can be made without permeation by hypothesis, and the full meaning of clinical findings can only be developed in the framework of theory, the difficulty of separating fact and hypothesis is not an accidental one. Further, it would be quite wrong to expect a simple correlation between the ratio of observational and hypothetical elements, and the scientific value of attempted formulation. A great number of data, by far transcending the immediate givens, and a considerable amount of hypothetical thinking have to be introduced in order to come to a conclusion.

The reconstruction of early childhood experiences in preverbal stages of development challenges our powers of formulation because the structure of the mental apparatus and the laws governing it may defy extrapolation from the more familiar later stages, and because experimental checks are not available. It is therefore imperative to study these by every method at our disposal, including that from observational data.

Yet concepts of mental processes are more than one step removed from behavioural data and from immediate experience. This remoteness is one reason why intersubjective testing of analytic propositions is arduous. Elements of behaviour similar in a descriptive sense may be genetically or dynamically different and vice versa. On the other hand what is the position of psycho-analysis in relation to the introspective schools? The difficulties of making an introspective psychology scientific have been met in psycho-analysis by the introduction of hypotheses on different levels, sometimes on a high level of abstraction, by means of which observable data become meaningful, sometimes to the point of prediction. Hypothesizing, based on self-observation, may play a more important role in psychoanalysis than in other sciences, and this process may

be additionally fruitful when the objectifying devices of the psycho-analytic method are brought to bear on it. This would be a fascinating object for the study of creative thinking in psycho-analysis.

While quantification is implied in many analytic concepts and as analysis moves further towards a general psychology may become more important, measurement at all costs, considering variables only from the angle of our capacity to measure them, would sacrifice essential elements of analytic research.

The approach to the validation of psycho-analytic hypotheses, through experimentation on men and animals, while so far not contributing to a reformulation of these hypotheses, overlooked the essential insight that hypotheses are primarily tools to be adapted to the demands in a given field, and was ignorant of the specific character of our subject-matter, and the complexities encountered by every method that strives for an explanation of personality. This understanding of hypotheses as tools suggests that progress in our science can best be expected from analysts themselves, able to judge the logical nature of these tools and test their fruitfulness in psycho-analytic work. Here it should be said that in addition to the work of objectivation which stems from the student's own analysis, there is much that is teachable and learnable about the methodological aspects of psycho-analysis as a science which could fruitfully be included in training curricula.

Ishak Ramzy, Ph.D., and Robert S. Wallerstein, M.D. (Topeka). ' Pain, Fear and Anxiety. A Study in their Interrelationships.' Pp. 147–189.

Within the framework of the basic principles of psycho-analytic theory, a working hypothesis has been suggested for the study of pain, fear, and anxiety. Pain is the sensation which signals a breach in the integrity of the body in relation to the external world, or a part or function of the body in its balance with the other parts. On the mental level of organization, this disruption of a physiological continuity is experienced as the perception of pain, which is thus ' the psychical adjunct of an imperative protective reflex '. An attempt is made to link up this original perception of pain with the various sorts of painful sensations, ideas, and affects experienced by the ego in sleep and wakefulness.

In physical pain there is a real boundary (between self and outer world), in which there is a real breach, a rupture of a physiological continuity. In contrast to breaches and boundaries which can be encompassed on the mental level alone, without reference to any reality correlates, is the existence in the presence of bodily pain of a breach which must be encompassed on two phenomenal levels simultaneously—the mental and the physical. The distinction between affects of non-bodily pain and the sensations of a bodily pain can perhaps be understood as a representation of the kind of boundary which is being breached. Anxiety is that affect which signals a danger to the integrity of the ego-id boundary, and guilt stands exactly similarly in regard to the relationship of the ego to the superego. In structural terms it becomes possible to trace the relationship of physical pain to mental pain and to point out some of the determinants of natural and pathological pains. It is suspected that the individual capacity to tolerate both would be found ultimately to derive from the same sources.

In genetic terms it is postulated that there is a close relatedness of primary pain and fear experiences to the nature and degree of the subsequent anxiety experiences. That is the proneness to anxiety; the ways of handling it and defending against it are assumed to depend upon the innate and developmental individual differences in the earlier experiences of pain and fear. The ' protective barrier ' has not only the function of keeping out excessive stimulation but of letting through appropriate stimuli necessary for the maintenance of organismic functioning. Basing themselves on Hartmann's concept of the undifferentiated phase, and recent ethological work, the authors describe the infant's earliest experiences of unpleasure as diffuse and undifferentiated states of psychobiological excitation and tension not properly to be called pain or anxiety. Anxiety is always a derivative experience, based on memory traces of previous pain or fear, and demanding therefore some primitive degree of ego integration, while fear may be either an innately determined (primary) experience or a derivative (secondary) experience based on prior pain. Pain is always in this sense a primary experience.

Max Schur, M.D. (New York). ' The Ego and Id in Anxiety.' Pp. 190–219.

The author discusses the importance to the problem of anxiety of the simultaneous availability of learned and instinctually patterned responses and their interlocking.

An earlier definition of anxiety (1953) is amended as follows: ' Anxiety is a reaction to a traumatic situation or to danger, present or anticipated. In this reaction we have to distinguish between the affect anxiety, which is an ego reaction, and the discharge phenomena which are also id manifestations.' The normal ego responses to anticipated danger operate to a large extent with secondary process, while the id element is what Freud probably had in mind when speaking of automatic anxiety. The term anxiety covers a complementary series, the economics of which are varyingly covered by degrees of fusion and neutralization of aggressive and/or libidinal impulses.

Considerations which are adduced and discussed for the proposed change are: the author's earlier distinction between anxiety concomitants and anxiety equivalents (1955); further evidence of discharge phenomena in preconscious processes;

the differentiation between instinctually patterned and the learnable aspects of the anxiety response, which has its counterpart in the mental apparatus in the differentiation of the structures ego and id, and the recognition that the discharge phenomena of anxiety are more suggestive of instinctual patterning.

The author's earlier formulations of the ontogenetic relationship between anxiety and instinctual demands, more especially between anxiety and pregenital sexuality, are supplemented now by phylogenetic considerations which make the link between sexuality and danger even more plausible.

Kurt Eissler, M.D. ' Notes on Problems of Technique in the Psychoanalytic Treatment of Adolescents, with Some Remarks on Perversions.' Pp. 223–254.

The frequency of symptomatic changes manifested by many adolescent patients suggests that no one technique can fulfil the requirements for their treatment. In his therapeutic dealings with the adolescent, the analyst has the following techniques at his disposal. With the classical technique, he can undo the damage of inhibition, or neurotic symptoms evoked by a too restricting reality; by the technique used with delinquents he is able to close the gaps in the patient's superego and curb his antisocial impulses; with the technique evolved for the acute phase of schizophrenia he is able to reconcile the adolescent with his total environment when he is endangered by withdrawal and surrender to the id with a minimum of defence. By instigating a conflict between the ego and perverted impulses, the analyst seeks to safeguard in the unconscious the cathexis of adequate heterosexual objects and of the genital function.

The ultimate and most difficult task is to synthesize these techniques. Except where the disturbance can be contained within one diagnostic category, the technique of treatment has to be correlated with the respective phase in which the patient's symptomatology moves. The widespread pessimism regarding the success of analysis in this period may stem from the rigid adherence to one technique throughout treatment.

The author discusses some dynamic factors in the phase which elucidate in part the evident ' liquidity ' of personality and gives some reasons why analysis presents difficulty at this time. In discussing the part played by masturbation in the life of the adolescent, he offers certain formulations on the psychology of orgasm and the nature of perversion, where the selectivity of conditions for orgasm is so conspicuous. The conscious part of the ego is forced to perceive and, if possible, to acknowledge as true certain conditions which disprove what is represented as true in the unconscious. The ego is then, depending on quantitative factors, endangered by accepting either the delusional representation of the unconscious, or reality as it exists, which entails intolerable anxiety. If in the state of orgasm, the ego succeeds in giving reality a structure that conforms to the unconscious representation, it escapes both alternatives.

Further comments concern the analyst's function of safeguarding the creative function of the patient which the author regards as open to damage in analysis at this period.

Elizabeth R. Geleerd, M.D. (New York). ' Borderline States in Childhood and Adolescence.' Pp. 279–295.

A review is given of recent literature on borderline states. The author discusses new aspects of an already published case of her own and adds notes on two further adolescent cases. In all these cases the disturbance of the ego is manifested in the pathological development of the object relationship with the mother. It consists in failure to develop that ' confidence ' in forthcoming gratification considered to be the basis of permanent object formation —hence the pathological intolerance of these children to frustration by the mother.

As a result of this failure, anxiety states reflecting the helplessness of the ego in the face of id demands can be observed. The anxiety in these cases is not a signal of danger but is in the nature of traumatic anxiety in the face of relatively mild frustrations. The reactions of such patients to the outside world are based on the intrapsychic model of the ego's helplessness in dealing with instinctual demands. The prognosis in such cases will depend both on the nature of the early ego deficiency and on the pathogenic influences of the environment and accidental developmental factors. Children of this type lack the confidence of gratification by the mother when they enter the phase of first recognition of the mother, in which they still consider themselves part of her. They react to any frustration by the mother as if it were a total loss, a disaster. Consequently and subsequently the differentiation between the mother and the self does not take place, or if so, only incompletely. The pathological results will vary in intensity and extent in each case.

Leo A. Spiegel, M.D. (New York). ' Comments on the Psychoanalytic Psychology of Adolescence.' Pp. 296–308.

In contrast with the relative fixity in latency of the three psychic systems, much of the disturbance of adolescence can be viewed as sequelae of disturbed intersystemic relations. The influx of sexual drives tends to disrupt the psychic apparatus. It is the task of adolescence to assimilate this genital sexuality into the self.

Another significant task is the establishment of a relatively fixed sense of self or of ego identity. The

anxiety and guilt from the reanimated Oedipus complex results in the withdrawal of cathexis from object to self representations with subsequent oscillations of cathexis between self and object. The creativity of adolescence may be linked indirectly to cathectic oscillations. Through artistic creation, self may become object and be then externalized and thus may help to establish a balance of narcissistic and object cathexes. Some aspects of preadolescent psychology in girls indicate a flight from the life of imagination and a maturational development of capacities for reality mastery which helps to withstand the narcissistic surge of adolescence.

While it is not possible to plot the vicissitudes of interstructural relations through the various stages of adolescence, the author makes a number of observations focussed on this area which have technical and prognostic significance when therapy is a consideration.

Annie Reich, M.D. (New York). 'A Character Formation Representing the Integration of Unusual Conflict Solutions into the Ego Structure.' Pp. 309–323.

The analysis is reported of a man whose history revealed an abundance of traumatic situations and a preponderance of regressed pregenital and sadomasochistic strivings. Conditions for the formation of good object relations and healthy identifications were far from favourable. Nevertheless the all-over result was an amazingly positive and ego-syntonic one. Important sublimations were formed, libidinal strivings found acceptable expression, and lasting object relations were established. The report aims at understanding how such successful character formation became possible in such difficult circumstances.

The operative factors are summarized as follows. The patient's capacity for melting together defensive patterns with slightly modified instinctual gratification was an unusual one. His ability to fit his adult sexual life into the frame of the curing-healing-giving compulsion may have preserved him from more serious potency disturbances and allowed him to obtain a substantial degree of gratification. The success of the synthetic function in integrating the wealth of pregenital fantasies into the realm of the ego may be explicable on the assumption that the ego could continually draw energy from the id, neutralizing it and using it for its own purposes. The ego possessed a particular capacity for sublimation based upon the solid structure of its defences but also on this free line of access to the id. His ability to solve his problems in a constructive way seems to have been rooted in some element of magic thinking, of preserved omnipotence. It was as though these regressively revived features of a primitive ego could be mobilized at will for purposes of reconstruction.

David Beres, M.D. (New York). 'Vicissitudes of Superego Functions and Superego Precursors in Childhood.' Pp. 324–351.

The abstract nature of the concept superego must be made more concrete by defining its specific functions. As listed by Freud these fall into two groups, those which prevent the expression of forbidden drives, and those which define ideals and values. Superego functions become manifest only through some recognizable ego functions. Thus such thought processes as memory, conceptualization, and judgement, and a certain level of intellectual development are necessary to distinguish moral values. Reality testing and object relationship play their part. The superego is an agency which increases the ego's capacity to recognize danger situations, more specifically certain kinds of danger situations. Its hallmark is the accompanying affect of guilt, itself an ego function.

The functions of the superego pass through recognizable developmental stages. Social compliance in early childhood may be achieved as ego response to danger situations. Turning of aggression against the self and reaction formation may then be looked on as precursors of the superego. The sense of guilt though an ego function is the hallmark of an internalized superego. It should be distinguished from the need for punishment. In children it may be associated with precocious ego development. Early transient identifications which fluctuate between introjection and projection and can add to the introject the child's aggressive impulses are to be distinguished from the more permanent identifications which mark the later developmental stages. For the child to incorporate within his psychic structure an agency capable of independent functioning, that is a true superego, there must be a corresponding establishment of a separate identity. The replacement of magical thought by reality testing and the development of some degree of conceptualization are also essential. The degree of neutralization of instinctual energy is an important factor in the stability of identification, the permanence of its internalization, and its orientation to reality. There is as yet no definite answer to the question of how far specific ego functions must progress to permit the structuring of the superego. Moreover in any one individual there will be an intermixture of archaic and mature superego features.

Clinical material is adduced covering deviant superego attitudes and the dynamics of ego-superego interrelatedness which they exemplify.

P. J. van der Leeuw, M.D. (Amsterdam). 'The Preoedipal Phase of the Male.' Pp. 352–374.

Attention is drawn to the significance, for the psychic development of the adult male, of the impossibility of fulfilling the preoedipal wish to be

pregnant and bear children like mother. The obstacles to be overcome are the feelings of rage, jealousy, rivalry, and above all the feelings of impotence and helplessness and the destructive aggression which accompany these experiences. In early childhood, childbearing is experienced as achievement, power, and competition with the mother. It represents being active like mother. It is an identification with the active producing mother.

This problem plays an important role in numerous men, and to elaborate these conflicts without suffering a disturbance in development is one of the greatest tasks in the preoedipal phase of the male.

Further research is necessary to establish to what degree this is generally true, how these problems manifest themselves in women, whether there are characteristic differences in the development of the male and female, or whether their development takes largely the same course or is even identical.

Analytical material demonstrates that conflicts arising from this difficulty may lead to the persistence of the identification with the preoedipal mother, that they may disturb the productive, creative activity and may be a factor in the genesis of perversions.

René Spitz, M.D. (Denver). ' On the Genesis of Superego Components.' Pp. 375–404.

The author examines the infant's experience of restraint at the hands of the adult for insight into the formation of superego nuclei or primordia (to be differentiated from the superego structure). While the role of the earliest forms of physical restraint is as yet insufficiently understood, the connexion of the mental experience of physical restraint with a fuller understanding of psychosomatic illness and hysterical paralyses cannot be overlooked. Restraint by gesture and verbal command which follows lead the child to imitate and identify with the object. Physical imitation probably rooted in phylogenesis has as much a part in producing these behaviour patterns as does identification. They originate in the child's insurgence against his infantile helplessness and serve the purpose of mastery. Later in the beginning of the second year the defence mechanism of identification with the aggressor will appear, notably of the adult's inhibiting ' No ', assumed first in gesture form and then verbalized. The child turns his gesture against both himself and the adult. Turning this gesture against the self marks the inception of a differentiating grade within the ego. As shown in the role-playing games of the child, the operation of this function is tried out playfully and its potentialities will be gradually explored in imaginary as well as actual situations. The author assumes that, on the one hand, the intrapsychic conflict between the libidinal and aggressive drives, simultaneously directed towards the love object in this achievement, will ultimately lead to the development of guilt feelings in the course of the second year. On the other hand the necessary condition for the development of guilt feelings is the differentiating grade within the ego which makes it possible to turn one part of the ego against the self.

While at fifteen months the child is able to distinguish and imitate the object's behaviour fairly exactly, the adult's mental processes and affects can be perceived at first only ' globally ', i.e. as ' for me ' and ' against me '. When in identification the prohibition is turned against the self and against the adult, the global quality of the affect is also appropriated. This behavioural entity represents energy transformation on a grand scale, a step towards the domestication of the drives in which the motor expression of the affect ' against ' has been subjected to the control of the ego and modified with far-reaching consequences.

From the viewpoint of thought processes, the gesture expresses a judgement and discloses the capacity to perform the mental operation of negation. This step will lead inevitably to the formation of the abstract concept underlying negation, the first abstract concept to appear in mentation.

Any abnormality in the development of the infant's object relationships will inevitably distort the developmental role played by these primordia and produce an ultimate defect in superego structure. Closer observation of the developmental sequences in the behaviour patterns discussed may ultimately be usable for diagnostic and corrective purposes.

Mary E. Bergen (Cleveland). ' The Effect of a Severe Trauma on a Four-year-old Child.' Pp. 407–429.

The analysis is described of a four-year-old child who with younger siblings had witnessed the murder of her mother by her father, a paranoid schizophrenic. She alone of the children who were subsequently fostered by a relative showed signs of serious reaction to the event. She organized the other children to reenact the murder in play and showed a compulsive need to tell strangers of the event while preserving silence at home about it. She ' confessed ' to other children her guilt at being implicated. Symptoms continued till the beginning of analysis, nine months afterwards. The history showed that Ellen's disturbance long antedated the breakup of her family and that she was already a quarrelsome impulsive child with strong tendencies to manoeuvre people and to plot and scheme to control every situation. Contributory events were the birth of siblings in quick succession at an early age, and the early necessity for the mother to withdraw needed care. Marked restriction of her motility and continued subjection to the primal scene had occurred.

The analysis indicated how one element of the horrifying event after another became involved with the child's own fantasy world, thereby receiving

weight through emotional cathexis. The child's preoedipal sense of frustration and her search for an ideal ' good ' mother found guilty fulfilment in her move to a new foster home. Her death wishes against three younger siblings served her identification with the violent but loved father. On the oedipal level, the murder of the mother gave reality to the guilt-laden wish to remove the rival parent. All the elements of the oedipal situation appeared in full force; love for the father, rivalry with the father, guilt for wishing to separate the parents, the effects of prolonged witnessing of the primal scene. The latter determined the child's deep involvement with that moment of the tragedy when the threatened woman tried to remove the children from the scene by screaming ' Get out of here '. In the analysis, this detail was shown to symbolize the crowning insult, the mother being experienced as trying to exclude the child angrily from the parents' intimacy.

Joseph S. Bierman, M.D., Arthur B. Silverstein, Ph.D., and Joseph E. Finesinger, M.D. (Baltimore). ' Depression in a Six-Year-Old Boy with Acute Poliomyelitis.' Pp. 430–450.

A depression occurring in a six-year-old boy with acute lower extremity paralytic poliomyelitis was studied as part of a long-term investigation of a series of children with poliomyelitis. The illness was perceived by the patient as a specified injury to the legs, as a more generalized injury to the body, and symbolically as a castration. He suffered a fall in self-esteem similar to that found in depressed adults. Both the child and his mother had phantasies about an oral cause, nature, and cure of poliomyelitis. Orality played an important part in the depression, oral-incorporative and oral-aggressive phantasies being prominent. Conflict was engendered by his oral-aggressive phantasies. The patient's mother showed both a depriving and overcompensating attitude toward the patient in regard to food.

A tentative formulation of the psychodynamics of the depression is offered. The hospitalization was perceived as a separation from and loss of the ambivalently loved mother who supplied narcissistic gratification. The patient's supplies from two sources of narcissistic gratification, his mother and his body, were partially cut off. The ingestion of food led sometimes to a restored state of omnipotence, at other times to vomiting, stemming from the patient's oral-aggressive desires. The expulsion of the introjected object took place orally instead of in the anal manner usual in adult depressives. Because of his propensity to restore the lost object in an orally incorporative manner, one may suppose that the lost object had been introjected and now resided in his stomach, the co-victim along with himself of the disproportionately severe parental punishment. The alignment of forces corresponds to the formula, superego *v.* ego plus introject.

While in infantile depressions so far studied there is an absence of data concerning the fall in self-esteem, the lowered self-esteem in this patient was comparable to that in the adult melancholic. In part this seemed to derive from the loss of the mother, but evidence was not lacking of the operation of the patient's immature superego to produce the formula ' I am worthless because I am bad and deserve nothing '.

Vivian Jarvis (Freeport, N.Y.). ' Clinical Observations on the Visual Problem in Reading Disability.' Pp. 451–470.

The author concentrates on the scoptophilic problem in reading disabilities. The active aspect of looking necessary to establish the automatic skill of reading rather than the reading content is felt to create the major difficulty. Clinical material is adduced to illustrate the major conflict between active and passive trends and the consequent inability to identify with one's own sex. Non-readers often have a greater reading vocabulary than is suspected, but alphabetical letters and words lend themselves to quick association with underlying fantasies and make resource to denial in the service of keeping such fantasies repressed, a constant feature.

A central notion in the fantasies is that of the phallic or castrating mother. Stupidity equated with craziness, badness, inability to read, is felt to result from masturbatory activity with injury displaced to the head, but at a deeper level is regarded as a symbolic castration, both ideas serving as a denial of real castration in either sex.

An understanding of the denial of voyeurism and compensatory exhibitionistic activities or fantasies should have important implications for reading therapy and for the teaching of reading in normal situations. Practical comments are offered on both these aspects.

William G. Niederland, M.D. (New York). ' Early Auditory Experiences, Beating Fantasies and Primal Scene.' Pp. 471–504.

Case material is offered in which the patient describes the immobilizing effect of noise during primal scene observations (' ground between millstones ', ' encased in cement ', ' pounded by a sledgehammer '). These sensations are reminiscent of ideas commonly expressed in the description of beating fantasies when the person beaten feels trapped, held tightly to the point of complete immobility, or otherwise made motionless. The author regards the threatening and uncanny quality of such experiences as the result of a fusion of auditory perceptions during the primal scene with earlier ones experienced at a stage in ego development when noise was something material, perhaps of an acutely threatening, or, in oral terms, engulfing or devouring corporeal nature. The present study suggests that

the concrete character of auditory perceptions evidenced by the young child and/or the psychotic appears to be based on the primitive nature of hearing. Although the latter is not fully explored, it seems permissible to regard the function of hearing (probably also extending to concrete thinking), and of physical contact as being closely related if not identical at a very early age. It is further suggested that under the impact of auditory primal scene stimulation, these primitive modalities of sound perception can be reactivated, and when later fused with the castrative aspects of the oedipal constellation, form the concrete core common both to the fantasies of being beaten and of coital violence during that period. During the oedipal period, the experiences derived from the sensory bombardment of early stages may combine with the castration anxiety of the oedipal phase and give an unusually severe and ominous character to the castration fear, *proprio sensu*. The oral introjective aspects, including the incorporation of the sounds emitted by the objects, can be viewed as the dreamer's attempt to regain contact with his objects, broken by the primal scene events, and therefore as an attempt at restitution.

Christine Olden (New York). 'Notes on the Development of Empathy.' Pp. 505–518.

Clinical material from the analysis of a child, and discussions with her mother, and the analysis of a second mother provided evidence of ego damage in both mothers which prevented them from sensing their children's needs, and in turn kept the children from developing adequate ego capacities with a sterilizing effect on their object relations and sublimations. The goal and function of the mothers' 'closeness' to their children was entirely narcissistic, namely to relieve depression when they were stimulated by their children's exciting experiences, sexuality, or outbursts. The children functioned to provide these experiences and to obtain a reciprocal share in the mothers' excitement. They were otherwise unaware of their own needs and wants.

The mother's unity with her child, complete before parturition, is disturbed by every developmental process which assists the child to independence. The child's incorporative processes are paramount in this respect in aiding development. There exists in the mother a need to maintain the biological condition of unity for a shorter or longer period, even though this need may be repressed, denied, or laden with aggression. During the first period of unity, the mother unconsciously senses the child's needs, drawing conclusions, sometimes mistakenly, from her own narcissistic self. Later physical gratification must be replaced in part by genuine interest, curiosity, and participation in the child's growth. Only thus is the mother helped to overcome the frustration of physical separateness, and to assume the role of provider for the child. A reciprocal process takes place in the child. When he feels 'provided for', he becomes able to tolerate his growing separateness and to form other attachments, on the basis of this understanding, initial relationship.

The roots of empathy may lead back to the primitive mother-child fusion, and disturbances of empathy may result, when mutual understanding does not in time replace the bodily-sensual awareness of each other's condition characteristic of the early months.

Phyllis Greenacre, M.D. (New York). 'The Relation of the Impostor to the Artist.' Pp. 521–540.

This paper makes a comparison of the nuclear findings which are characteristic of the major impostor and the creative individual. The author draws together her findings in two other papers, one on the impostor and the other on the creative artist's childhood. The impostor suffers from an incompleted development of the ego involving defective ability to form object relationships and a special disturbance of the sense of identity. Ego defects derived from strong pregenital fixations cause a thin but dramatic enactment of the oedipal conflict which is constantly re-enacted in each imposture, the imposture itself being most often the assumption of the identity of an oedipal figure, with a real or illusory assumption of his power. The artist is at least two people, the personally oriented self and the artistic one. The artistic child may react to the external world in the direct personal way characteristic of the maturational forces of the ordinary child, and his libidinal attachments develop in the direction of normal object relationships. But with his greater perceptive response to both form and rhythm, the personal objects of his immediate human environment may be invested with a greater range of other outer (often inanimate) object perceptions, related to the personal objects by similarities in form or rhythm. This means that all object relationships may be felt and expressed with a vast increase in their symbolic representations. These characteristics constitute the access to primary process thinking, the retention of which into adult life is characteristic of the artist. This 'field of collective alternates' offers alternates for the specific objects of the human object relationships and is frequently invested to a greater extent with fantasy.

Both in the creative artist on the brink of a new surge of creativity and in the impostor, between periods of imposture, there is a sense of ego hunger and a need for completion—in the one of the artistic self; in the other of a satisfying identity in the world.

The author discusses at length Thomas Mann's preoccupation with the problem of imposture and the evidence that his attraction to this theme was in part rooted in the common search for a completed identity.

Philip Weissman, M.D. (New York). 'Shaw's Childhood and *Pygmalion*.' Pp. 541–561.

The author examines the play *Pygmalion* from a psycho-analytic angle, demonstrating that its plot reflects the author's early life and family history. The contents of the early experiences shaped the author's conflicted state during the period when he conceived of the play and also during its subsequent production. Use is made of Greenacre's concepts, the artist's world of 'collective alternatives' and the artist's resolution of personal conflict in a 'love affair with the world'.

Shaw's career was marked by acting out in vivid personal relationships of early oedipal conflicts, alternating and overlapping with attempted resolution in creative works. Shaw's infatuation with Mrs Patrick Campbell—an 'object of the world' as famous actresses are likely to be—was quickly neutralized into a created image for an artistic future production when he fantasied her as an East End donna in a play. This remained in abeyance for fifteen years till the period of his mother's final illness. This event evoked the childhood images of his mother and mobilized him to create Eliza, with the transitory object of Mrs Campbell—a conscious, desexualized world object—as the inspiration. After the completion of the play and after the death of his mother, the sexualized altercation between Shaw and Campbell occurred.

The creations of the artist are often the rearranged responses to the primal object (mother's breast), expressed in aesthetic forms (Greenacre 1957). The artist's created object, steeped as it is in the early maternal object, is often embellished with his own omniscience and omnipotence, as Galatea was by Pygmalion, Eliza by Higgins, and Mrs Campbell by Shaw, and finally as Shaw's mother in his childhood was by him. Higgins is saturated by omnipotence which he projects into Eliza and then returns to himself, in the same way as small children in normal development attribute such omnipotence to their parents and then reassign it to themselves as they dethrone the parents. In Shaw these magical factors were overdetermined and subject to a pregenital fixation in his object relations, due to the specific depriving nature of maternal care in infancy and early childhood.

Ruth Thomas.

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Members and Associate Members of the International Psycho-Analytical Association are reminded that competitors for the Clinical Essay Prize must send in their work to the Hon. Scientific Secretary of the Institute of Psycho-Analysis, 63 New Cavendish Street, London, W.1., by 31 May of the year in which they wish to enter the competition.

The conditions governing the competition are the following:

A prize of £20 is offered.

Requirements for the Essay

The essay shall consist of a clinical record of a case investigated by psycho-analytical methods. It should illustrate clearly the events and changes in the mental life of the patient and their relation to external environment. In awarding the prize, the Judges will pay attention to acuity of observation and the clarity with which the facts are stated. If the writer wishes to draw theoretical conclusions, he must bear in mind the necessity of making the evidence for such conclusions carry conviction.

It is recommended that the length of the essay should not exceed 20,000 words.

The Essay shall not have been published in any book, journal or other form of publication and shall not have been read to or have formed the subject of discussion at any formally constituted meeting of psycho-analysis.

Date of Sending in Essays: Language: Format, etc.

Essays must be submitted on or before 31 May in any year. They must be in the English language, in typescript on quarto paper with ample left-hand margin. They must be in triplicate and be sent to the Hon. Scientific Secretary of the Institute. All copies of essays submitted become ipso facto the property of the Institute (or its successor) while it has the appointment of the Trustees for the Prize Fund.

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If no essay of merit worthy of a prize is submitted in any year, no award shall be made for that year.

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The competitor to whom the prize is awarded in any year may be called the Clinical Prizeman for that year.

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and Bulletin of the

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